Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS.G903.5/21/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jennings Wootteon Wootthon Physician/ May Month 1^{Day} 2010 Jennings 12:26AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 102 South Long Cross Road Linthicum Anne Arundel 5. Social Security Number 6. Sex 1 M 2 ☐ F . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Months Oct. 17,1925 84 **Director** 216-20-6154 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Linthicum 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 South Long Cross Road 21090 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No If Yes, Give Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 Divorced White Completed Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Sales Correspondence Stee1 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Frank Edward Wootteon Mary Alice Crabbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Helen Wootteon /Wife 102 South Long Cross Road Linthicum, MD 21090 Baltimore, Date 25, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State May 2010 4 Donation 5 Other (Specify) Meadowridge Mem. Parl Elkridge, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TSIOPATHIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Yes by the a g Unknown g Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown REPLEX LISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 12110 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending s after death | Director: A d in by the f Accident Investigation Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15+1 22875 2010 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrer's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month MAY 2010 Year LORRAINE WASHINGTON 2:34 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Furneral (Month, Day, 1 □ M 2 🗓 F Months Days Hours Min. Director WASHINGTON, DC 577-62**-**5214 84 AUG. Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Yes 2 No MONTGOMERY SILVER SPRING MD 10e. Street and Number 9 10f Zin Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a 0 traumatic event, the Medical Examiner must be Funeral 8715 1ST AVENUE 131C 20910 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Black, White, etc.
BLACK Armed Forces?,
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 XWidowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene, marked other than GOVERNMENT TEACHER 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HOWARD BROWN EVELYN PATTERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WASHINGTON/DGT LAURA Health tem 27 1103 LILAC COURT UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 🔀 Buria! 2 🗆 Cremation 3 🗆 Removal from State 0 cemetery, crematory or other place, Department C Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 5/27/2010 LANDOVER, MARYLAND Signature of Pun all Sarvice Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir death certificate be executed burial-transi and that initiated events resulting in death) Last anding physician use as the burlal Physician/Medical Diyision of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? 1 ☒ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briector, page 2 s autopsy performed? 1 ☐ Yes 2 🔀 No Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ပ္ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the only one)

State Registrar

MAJID RHAMANIAN SHAHRI M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hmani-

13, 2010

29c. License number

D66372

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6125 am Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Ritchie Hospice Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth 1 € M 2 □ F 218-36-9346 Months Hours Min. (Month 69 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a State 10b County death with the Maryland 10c. City, Town or Location Funeral Director 10d. Inside City Limits N/A MD Baltimore 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1700 Edmondson Ave. #4 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Completed by ☐ Yes 2 🔀 No 3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 Yes 2X No Specify: Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Construction 12th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Otterbridge Hattie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orisatolu Aduke-Taylor 69 Broadship Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Mt. Zion Cem 5/25/10 Lansdown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBeverly D. Cromart 2700 Edmondson Ave. Balto., MD Cromartie F& to., MD 21223 23a, Part 1. Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Ph sician/ Onset and Death Medical resulting in death) Examiner Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Due to (or as a consequence of): the attending physician shed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death' certificate Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 2V/ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this Hospice eral Director; After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Deal 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 Tes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a
To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 1613 Aisquith Street		. 10f	Zip Code 2120	02		10g. Citizen of What Co	ountry?		
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and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Lewis Smith				18. Mother's Name Betty	e (First, Middle, Easte				
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390 pm	f Health item 2; other t		Norma Smith Niece 20a. Method of Disposition		ace of Disposition	(Name of		Date	20c. Location - City or			
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Ba	permit Depar Impor any in		21. Signature of Edneral Service Ligensee			e and Addres 101 E	s of Facility ! . North		East F/H e Balto,	MD 21202		
			23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each	sed the death. line.	Do not enter the	node of dying	g, such as cardiac o	or respiratory an	rest,	Approximate Interval Between Onset and Death		
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0. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	23b. Was decedent pregnant 23c. If yes, outco	th 2 ☐ Fetal ntattime of de	death 3 Ecto	pic pregnanc er (spec <i>ify</i>)	у		23d. Date of de Month	elivery Day Year		
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24a. We authorized to medical stammer? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of injury 3 Suicide to Could not be determined to building, etc. (Specify) 29a. Certifier 29a. Cer									Street and Number or Ru vn, State)	ural Route Number,		
	e Hospita 124 hours Funeral leted filled	edical	29a. Certifier (Check 2 Medical Examiner: On the besis	of examination	and/or investigatio	n, in my opinio	on, death occurred a	t the time, date a	and place, and due to the	cause(s) and manner stated.		
	To the within To the compl	2	29b. Signature and title of certifier	zoot omity	Lego, tress	29c. License	number	,	29d. Date signed (Mont			
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	Sta		31. Date filed (Month, Day, Year) On Louren COUSING BIO	istrar's Signatu		nden	N Ba	17, 140	2/201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 3:05 AM Windsor 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death ia 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** March 23 1928 1 ☑ M 2 ☐ F 212-24-7501 MD Director 82 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 186 llth Street 21122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 ☑ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Meat Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Griffith Windsor Sr. Elizabeth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Myers (daughter) 333 Hamberg Avenue, Essex, MD 21221 Date 21 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery Baltimore, Maryland 21. Signature f Funera 22. Name and Address of Facility cryica License Stallings Funeral Home, P.A. 3111 Mountain Road, PAsadena, MD 21122 hal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complic shock, or heart failure. List only one 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final 10 Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of, ri any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗆 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 🖭 Unknown 1 \square Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy autope, performed 2 this certificate 1 🗌 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After t 1 V Natural 5 Pending work' 1 🗌 Yes 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CKS MI WVVIR 31 Date filed (Month. gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

annie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ Ruth M. Williams 2010 7:05 A.M Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** City 6112 Everall Avenue Baltimore Social Security Number 8. Date of Birth Nov. 14, 1930 If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2XX Months Days Min. 220-24-8668 West Virginia 79 Yrs. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f st notified Baltimore Baltimore Maryland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States er than "natural", or items 23a o 21206 Funeral 6112 Everall Avenue of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 5-0036 white 1 Yes 2 X No Specify: If Yes, Give Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper St. Dominics Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myrtle Mullenax permit. Page 1 and 2 should be. Department of Health and Menta Raymond Jim Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Carolyn Y. Matthews/daughter Department of Health a Important: If item 27 is any injury or other tra 8727 Stockwell Road Baltimore, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Rosedale, Maryland Gardens of Faith 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Lice see Peaceful Afternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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MAY

Box 68760. P.O. Records, or Vital Division the Hospital or Attending

Baltimore, Maryland 21215-0036

29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Image: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D33599 05-18-2010 s of person who completed cause of death (Item 23a) (Type, Print) Dr. Phillip 125 Airport Dr. Suite 34, Westminster, MD 21157 Ruzbarsky 32 Registrar's Signature Banker 31. Date filed (Month, Day, Year) Registrar **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ay 17,2010 Physician/ Charles K. Weiss May 13:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Forei (Month, Day, Year) April 26,1943 West Virginia If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Director 219-42-9621 67 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine man Leader of the management of the Medical Eventine man and Injury or other traumatic event. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 4829 Vicky Road 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent ______ Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. Co. Public Works Adminstrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mable M. Kelley Paul R. Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 4829 Vicky Road Diane H. Weiss Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-20-2010 4 Donation 5 Other (Specify) Most Holy Redeemer Balto. Md. 22. Name and Address of Facility Schimunek Funeral Home Signature of Fund rvice I once. Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Melaroma months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No by the a 9 Unknown been signed by should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an after death.

Director: After this certificate has I in by the funeral director, page 2 s autopsy Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred X Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12149194 17. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant 701 Charles N. Towson MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DARLENE WEBER MAY 04: 45AM 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X□ F 58 Months Hours Min. May 12ay, Yar 1952 Maryland 214-58-8860 **Director** Usual Residence of Decedent fshow or 28a-f shov notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 72 hours after death with the Maryland Director MD N/A Baltimore 1X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be Funeral 2806 Sunset Drive 21223 United States items; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 9 þ 21215-0036 1 ☐ Yes 2 X No Specify. White 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Specify: and Mental Hygiene. Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker 10 Own Home Page 1 and 2 should be filed w treent of Health and Mental Hygi rtant: If item 27 is marked other ijury or other traumatic event, t Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Bilbo Marie Iron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Weber - Husband 2806 SUnset Dr., Baltimore, MD 21223 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cometary, crematory or other place) permit. Page 1 Department of Important: If it 1 XBurial 2 Cremation 3 F 4 Divation 5 Other (Specify) any injury or 2 ☐ Cremation 3 ☐ Removal from State budon Park Cemetery 5-21-2010 Baltimore, MD 2. Name and Address of Facility o uneral Service Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1: Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final PHEDMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ARTERY DISEASE CORONARY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IZCHEMIC CARDIOMYOPATHY Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Vear 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No the g Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed b 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE Records, No 3 ☐ Probably 4 ☐ Unknown 1 Tes DEM BUTIA 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has lirector, page 2 s Jas autopsy BIPOLAR performed? MISORDER Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medica **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မှ Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? Natural Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State DHMH 17 Rev 7/2009

Registrar

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ARTIK J. DEJAI

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

APTIX J. DETAI MD 3290 N. Ridge Road, Swite 100

PHYSICIAN

32. Fegistrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062704

		For State Registrar	State of M	arylaı		artment of l		Mental Hy	/giene Reg. No.2	1	16010
		Decedent's Name (First, Middle	, Last)					2. Date of De	large Coll	10	3. Time of Death
Physicia		Robert Delma	Wilson					Month 5	Pay Day 2	Year	900 PM
/Medic Examin		4a. Facility Name (If not institution	give street and number)			4b. City, Town, o	or Location of Deat	h	4c. Count	y of Death	
4		FRANKLIN Squa	ere Hospita	21 C	enter	Ros	sedale		Ba	CTIN	nore
Funeral		5. Social Security Number	6. Sex 7. Ag 1 🛣 M 2 🗆 F		. last birthday	If Under 1 Year Months Days			rth ay, Year)		place (State or Foreign
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r dea	nue	11. Maritai Status	12. Was Decedent Armed Forces?			Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No	o- 14. Ra	ce - Americ	
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uld b Menta Irked	10	Cyrus Wilson			•		Caroline	e Beam			
and and aum	Ì	19a. Informant's Name/Relationsh				ng Address (Street					Code)
and lealth m 27 her tr		Rosemary Wilson	(Wife)	-	_1	orque Way	·	ore, Mar	ryland 2	1220	
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Depa Impo any i	1	21. Signature of Purpoul Secure t	consee		2	2. Name and Addre	ss of Facility uzdzinsk	i Funera	al Home,	P.A.	and 21221
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Obvestatava		23a. Part 1 Enter the disease, or of shock, or heart failure. List of Imprediate Cause (Final									Interval Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								
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detached	hys	9 Unknown	9 🗌 Unknown			(-,,/, _					
	by P	Part II. Other significant condition	s contributing to death bu	it not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to th	e cause of death?
been signature should b								1 🗆 `	Yes 2 □ No	3☐ Prob	ably 4 hnknown
has be	Completed							24a. Was	an 24b.	Were autor	psy findings available
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certificate ector, pag		25. Was case referred to medical examiner?					26. Place of Dea				
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After funer	<u>o</u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry (, Year)	28b. Time of Injury	Worl		28d. Describe I	how injury occur	red	
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within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical E	caminer: On the basis of and manner sta	examina	tion and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
To t	Σ	29b. Signature and title of certifier	0			29c. License	e number		29d. Date signe	d (Month, L	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8,10f,19a per inf g905 7-26-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY CHANG YUN 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROCK MOINEGOMER, ROY OSP 8. Date of Birth 1915 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 90-301 1 № M 2 🗆 F Months Days Min **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director MONEGOMER 1 Yes 2 No 10e. Street and Numbe 20853 10g. Citizen of What Country? Funeral IEIRS US17 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married "natural", or Completed by 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ASIAN 3 Widowed 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hour latfment of Health and Mental Hygiene. ordant: If item 27 is marked other than "naturinjury or other traumatic event, the Medical injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) CARMING Elementary/Seconday (0-12) College (1-4 or 5+) FARMER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 20534 FLOWER 3 56 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other REC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur un al Service Lice 22. Name and Address of Facilit 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner year HRENIC DESTRUCTIVE PULM DISENS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ied by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? ģ Foulure Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 1 Yes of Vital completed filled in by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital: Other: 2. ☑ No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division death. 2 Accident
3 Suicide
4 Homicide М after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 11, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Gailhersburg My 14220 4213 105 Frederich 31. Date filed (Month, Day, Year) 32. Reginar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 - State Amend Items 23aPtI,II,25,27,28a-f. per me, g903,05/21/2010dhb Registrar Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY 3, 20 0 Physician/ 5:00P MARGARET ELLEN BUCKLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MD. HOSPITAL CENTER PRINCE GEORGES CLINTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral MD ountry) 1 □ M 2 🖫 F Months Days Hours Min. 100-175-1920 579-16-8113 89 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MD. CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12492 IDLEWOOD PARK ROAD 20601 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. ıral", or iten I Examiner n Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specif WHITE If Yes, Give Year or Dates 1 Yes 2 XNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examone. 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ANDREW AIR Elementary/Seconday (0-12) College (1-4 or 5+) RECEIVING CLERK FORCE BASE 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ NELLIE AMELIA MOORE GEORGE WILLIAM HART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8\,1\,1\,0\,$ JOHN SAM RD $\bullet\,$ CLINTON , MD $\bullet\,$ 20735 19a. Informant's Name/Relationship (Type, Print, PATRICIA KING-DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS 5-7-2010 WALDORF, MD. 4 Donation 5 Other (Specify) Signature of Mneral Service Licensee M00479 2 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratorn Physician/ disease or condition resulting in death) Medical Examiner Blunt Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and APPROVED BY MEDICAL EXAMINE that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical CERTIFICATION Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year for Month 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No certificate Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Bel examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PR/Outpatient 3 I DOA |2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 05/03/2010 5 Pending Natural within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident Multiple falls Unknown M 1 Yes 2 X No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 12492_1dlewood determined Park, Waldorf, MD Home and Yard Medical Typertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar

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State

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05/04/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month MAY Day 2010 Year Physician/ 10:05 PM BURNS RUBY EVONNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days April 30,1941 1 🗆 M 2 🔀 F Virginia 69 **Director** 228-68-6059 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral United States 21701 102 Evergreen Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 Yes 2 X No Specify: **Black** 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School Board 12 Assistant Librari<u>an</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Fox Hardin Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Barry T. Burns/ Husband 102 Evergreen Court, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.5/11/10 Frederick, Maryland Signature of Juneral Service License 22. Name and Address of Facility 22. Name and Address of Facility
Stauffer Funeral Homes P.A.
1621 Opossumtown Pike, Frederick, Maryland Opossumtown 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic avacian disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and s been signed by the attending physician and should be detached for use as the burial-transit Acure renal that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has be funeral director, page 2 s performed 1 Yes 2 No Yes 2 X N 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The destriction of the cause of the least of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062975 5/31 enham us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOR WESHOLD THE ST, Frederick MD 2i 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2, 2010 3:45 p Grace Teresa Berardi М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign D. Country) Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🖺 F Months May 20, 1926 578-28-1134 83 Yrs. Director Usual Residence of Decedent Show . Page 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shon jury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes XX No Kensington Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20895 USA 3911 Kincaid Terrace Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Forces þ 1 Never Married 2 Married Yes Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth L. Landini Frank A. Pennini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1762 Mincey Terrace, North Port, FL 34286 Frederick R. Berardi, Sr./Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 6, 2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee Francisd de Colfins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Advanced Pulmonary Disease Sequentially list conditions. Due to or as a consuluence of cause. Enter Underlying Exami Respiratory Arrest attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) q ☐ Unknown detached g Unknown is been signed by it should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗗 No 1 Inpatient 2X ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🔃 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nooshin Farr, MD 1500 Forest Glen Road, Silver Spring, MD 20910 1 31. Date filed (Month Pay) egistrar's Signature State 10 2010 Earles Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 05/03/2010 RUPERT DONOVAN BARRETT 1315 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 07/19/1950 1 X M 2 □ F Jamaica Director 59 2<u>66-31-</u>5476 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 □ No MD Derwood Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20855 Jamaica 7516 Oskaloosa Terr. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc δ 1 Never Married 2X Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AFL-CIO Glass glazer 12th is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stanley L. Barrett Sylvia Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Oskaloosa Terr, Derwood, MD 20855 Jennifer Pegram Barrett - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or or 1X Burial 2 ☐ Cremation 3 ☐ Removal fi of Heaven 5/15/10 Silver Spring, MD nation 5 Other (Specify) Snowden Funeral Home re of Funeral Service 2. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 complications that caused the death enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the disease, or o Approximate Interval Between shock, or heart failure. List Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PANCREATIC Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 9 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s has autopsy perform 1 ☐ Yes 2 No certificate Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' Natural 5 Pending death. 1 🗌 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature 29d. Date signed (Month, Day, Year) 03, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR 18111 Prinu OLNEY. JOSEP4 KAOLA 31. Date filed (Month, Day, Year) **MAY 0 6 2010** 32. Registrar's Signature State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Atif Zeeshan Aatt 9733 Health way Drive

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10d & 19a per Fh g904 6/23/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 5/3/2010 8:15 P Anna Lankford Blocker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 11414 Norris Twilley Rd
5. Social Security Number 6. Sex Mardela Springs Wicomico 8. Date of Birth (Month, Day, Yea 5/14/1919 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F 90 Yrs MD Director 180-16-5822 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I've Medical Examinar must be neitified at ury or other traumatic event, I've Medical Examinar must be neitified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Funeral Director MD Wicomico Mardela Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11414 Norris Twilley Rd. 21837 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Specify: White 1 ☐ Never Married 2 ☐ Married 1 □Yes Ž□No Saltimore, Maryland 21215-0036 Specify \$ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lab worker DuPont 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Luther Lankford Hattie Marine ပ 19a. Informant's Name/Relationship (Type. Print)
Brenda Blocker Robbins
Brenda Robbing (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5617 Sharptown Rd. Rhodesdale, MD 21659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 Frankford DE Cape Henlopen Crematory 22. Name and Address of Facility The Burbage Funeral Home 21. Signatur of Funeral Service L Muscah 108 William St. Berlin, MD 21811 23a. Part 1 Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Ulsease on injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an After this certificate has I funeral director, page 2 s autopsy 1 □Yes 2 ☑ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 SAUISBURY DH3 sveir 1415 SIDLU VE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

10-03645 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Browning Corbin 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1829 hrs May 11, 2010 Medical Examiner Joseph Browning Corbin 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Silver Spring Montgomery 12913 Layhill Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreignWashington Months Days Hours Director 04/15/1948 62 216-50-9012 1 X M 2 F Yrs DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho MD Montgomery Silver Spring Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 20906 12913 Layhill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 11 Marital Status Armed Forces? White, etc. 1 X Never Married 2 2 X No Yes White 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 Hairdresser Salon 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) "unknown" Corbin Rosette Kleinman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 408 Gilmoure Drive, Silver Spring, Maryland 20901 Andre Berman, cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 05/13/2010 Mt. Lebanon Cemetery Adelphi, Maryland Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike. Rockville, Maryland 20852 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death aHypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician per ME g904 6/3/10 TT ,PII Box 68760. IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ 1 Yes 2 No 3 Probably 4 V Unknown Alcohol abuse; Hepatitis C Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed Yes 2 ✓ No 1 Yes 2 No Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 🗸 Other Scene Inpatient ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending ector: by the i Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 24 hours after Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 12, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 03, Year Physician/ 2010 7:53 P M Stella E. Curran Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Derwood Montgomery Sycamore Acres If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numb 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. 171-24-5948 1 🗆 M 2 💢 F Dec. 30, Year 1921 England 88 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am jointy or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director Gaithersburg Montgomery 1 Yes 2 K No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 United States Funeral 8208 Langport Terrace Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Accounting Accountant 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Edith Burgess Arthur Tranter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8208 Langport Terrace, Gaithersburg, MD 20877 Janet E. Curran (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State May 7, 2010 Germantown, MD All Souls Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility DeVol Funeral Home, M00689 MD 20877 10 East Deer Park Drive, Gaithersburg, Flart of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sjogrens Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus, Type 2 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Emer Underlying Cause (Disease or iinjury Exami the attending physician and hed for use as the burial-transit Dementia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 2 ☐ No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) 1 ☐ Yes 2 🖺 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: A filled in by within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850 Irina B. Sherman, M.D., 31. Date filed (Month, Day, Registrar's Signatur

Suema

Registrar

Medical

29a, Certifier (Check

only one

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D52832

29d. Date signed (Month, Day, Year)

May 4, 2010

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Year Physician/ CAULFIELD DONALD 2:00 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 101 Watkins Pond Blvd. Apt. Rockville Montgomery 203 . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 💢 M 2 🗆 F 83 Months Hours Min. 12/14/1926 New York 119-16-6594 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director 1 Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20850 United States 101 Watkins Pond Blvd. Apt. 203 "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1946
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 K Married altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Law Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mary Murray Joseph Caulfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
101 Watkins Pond Blvd. Apt. 203 Rockville, MD 20850 19a. Informant's Name/Relationship (Type, Print) Patricia Caulfield (Wife) 1 and 2 s of Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate fo Heaven Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date Department of I Important: If its any injury or of once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 1 RACE 10 East Deer Park Dr. Gaithersburg, MD 20877 TUVER. 1011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Arteriosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ending physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρģ in the past 12 months? Month Day Year 5 Other (specify) 2 No cate has been signed by the page 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Multiple Cerebral Vascular Accidents 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 👿 Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) May 4, 2010 D0055522 9+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) MAY 06 2010



Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Itemstates of Marsland / perparting to 100 to 100 North Hygiene 2 U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year Ma^{Month} Michael Chestle 6. 5:25 P. M Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16th Street <u>Chesapeake Beach</u> <u>Calvert</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🕅 M 2 🗆 F 1277971971 Pennsylvania 68 175-32-4490 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1 X Yes 2 No MD Calvert Chesapeake Beach 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3804 16th Street 20732 U.S.A Page 1 and 2 should be filed within 72 hours after death w nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 Divorced Completed Year or Dates.1959-63 the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) telephone company supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Chest1o Pesta Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Chestlo, wife 3804 16th Street, Chesapeake Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Femoval from State 4 Donation 5 Other (Specify) any injury or MD Veterans Cemetery 05/11/2010 | Cheltenham, MD 21. Sign property of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home. P.A. 8325 Mt. Harmony Lane, Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ed by the attending physician and detached for use as the burial-transi CERTIFICATION P OF D that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed^a 1 Yes 2 1 No Hospital or Attending Physician: The 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month. Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 🛣 No Subject fell Natural 5 Pending Division 05/04/2010 **Unknown**^M 2 X Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3804 16th Street Chesapeake Beach, MD determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5435 104/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PR FRED, MD HOSPITAL ROAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

DHMH 17 Rev 7/2009

10-03446 Christopher Michae		sure All Copies Are Legible. and Mental Hygiene
Physician Medical Examine	I- For State Registrar 1. Decedent's Name (First, Middle, Last) Clause the order of Death Consol	2. Date of Death
iwedical Examine	Christopher Michael Carey 4a. Facility Name (if not institution, give street and number) 16129 Drayton Farm Drive 4b. City, Tow Burtons	wn, or Location of Death sville Ac. County of Death Montgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 218-31-4622 1 Months	1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Days Hours Min. July 26,1988 Foreign countil) ary land
the Maryland s or 28a-f show any tified at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Spencerville 10e. Street and Number 10f. Zip Co	10d. Inside City Limits 1 Yes 2 No ode 10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If it firm 27 is narked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Finneral Director	1 Never Married 2 Married Armed Forces? If Yes, specify 0	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)
5-0036 ed within 72 hours after tygiene, and cheer than "natural", the Medical Examiner.	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oc	ccupation (Give kind of work done ng life. DO NOT use retired)
21215-0036 Juld be filed within 77 Mental Hygiene. marked other than cevent, the Medical	17. Father's Name (First, Middle, Last) Michael S. Carey	18.Mother's Name (First, Middle, Maiden Surname) Linda P. Glumac (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, MD 21 and 2 should ealth and Mc em 27 is ma rem 27 is ma		ton Farm Drive Spencerville, MD 20868
Baltimore, permit. Pages I an Department of Hes Important: If ite	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 1 X Burial 2 Crematory or other place) 1 X Donation 3 Removal from State 1 X Burial 2 Crematory or other place) 1 X Donation 5 Other Specify: 2 X Name and Ad Donation 7	metery 5/11/2010 Washington, DC definess of Facility Borgwardt Funeral Home, PA der Mill Road Beltsville, Maryland 20705
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of calculure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
ecuted and transit	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Course (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	
cecul	X UNPENDED	3 Ectopic pregnancy 23d. Date of delivery Month Day Year
P.O. es that the igned by be detach	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this centificant of the funeral director.	1 Ves 2 No 1105ptell: 1 Inpatient 2 ER/Outpatient 3 DO/ 27. Manner of Death 1 Natural 5 Pending Investigation Investigation 28e. Place of Injury - At home farm street factory of	c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 X No unk 28f. Location (Street and Number or Rural Route Number, City
DIVING PROBLEM OF THOUS After Property Division (ely filled in Cortification)	Suicide 4 Homicide 4 Homicide Specify) house Specify house Certifying Physician: To the best of my knowledge, death occurred at the tire	or Town, State) 16129 Drayton Farm Dr BUrtonsville, MD me, date and place, and due to the cause(s) and manner as stated.
To the He within 24 To the Fit completel	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my or and manner stated.	ppinion, death occurred at the time, date and place, and due to the cause(s) License number 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E. May 5, 2010
Stat	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimo 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DHMH 17 Rev 1/200	ORIGINAL	OCME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:20 DONALD EUGENE DINTERMAN May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 8. Date of Birth 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 D F Months Hours Maryland 1.92: 87 **Director** 219-36-2593 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 U.S.A. 108 West Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Painter Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Roy C. Dinterman Nettie V. Stambaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1015 South 20th Street, Arlington, VA 22202 19a. Informant's Name/Relationship (Type, Print) Belva J. Dinterman / Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 5/7/2010 Thurmont, Maryland Blue Ridge Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Servi & License ROBERT Address DATLEY & SON FUNERAL HOMES, Sut ! ٤ 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final COPD Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a MOD63498 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 400 W 7th St akhvinder Wadhwa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Cenera.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 20b per fh g903 5-24-10 vt/ #20b, perff, G904, 6/7/10, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician April 30, 2010 9:45 a Robert Henry Falk /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Nursing & Rehabilitation Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 **X**M 2 □ F New Jersey 10/11/1932 Director 147-24-1609 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □No Director Maryland | Frederick Monrovia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4308 Weller Court 21770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3√∑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chemical Operator Factory 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Russell Falk Hazel Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21770 4308 Weller Court, Monrovia, Maryland Richard Falk, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 17 1 Purial 2 X Cremation 3 Removal from State $05/\frac{19}{2010}$ Falls Church, Virginia 4 Donation 5 Other (Specity) National Crematorium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 MO1255 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 504/03)5050/3 U /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown TO ANALY ST Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a Was an autopsy performed? Yes 2.2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital 2 1 Yes 2X No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state(). (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0051280 4-30-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anushiravan Dadgar, 10110 Molecular Drive, Suite 206, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

0 6 2010

10-03370 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Foreman State of Maryland / Department of Health and Mental Hygiene 1- For State RegistrarAMEND#20a, b, coerFH, 5/12/10, BW, Gertificate of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Day Month Da May 2, 2010 Medical Examiner 0155 hrs JAMES FOREMAN 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Montgomery General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Foreian Director 02/11/1937 Country) MD 1 XM 2 F 73 Yrs 215-36-3141 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 X No Rockville Montgomery Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 12630 Veirs Mill Road, #211 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian Black nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or items: other traumatic event, the Medical Examiner must be. Armed Forces? White etc. 1 Never Married 2 XMarried 2 X No Yes If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 X No specify: Black 2 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Concrete Finisher Private Company 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ Corrine Johnson Marshall Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asbury Methodist Nursing Home, Gaithersburg, MD Amanda Hall Foreman - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Argenty Cremation Svc Sate of Heaven 1 X Burial 2 X Cremation 3 Removal from State Hanover, Maryland Silver Spring, MD Department of 4 Donation 5 Other Specify aure of Funeral Servio permit. 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the dis Physician ase, or co Between Onset and failure. List only or /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit law requires that the death certificate be executed Physician/Medical the attending physician red for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? signed by contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been a 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed ✓ Yes 2 No this certificate 1 Yes director, 26 Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other. 2 PER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural 1 Yes 2 No Pending Funeral Director: stely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide

Hospital or Attending Physician: 24 hours after death. To the Hos within 24 h To the Fun

> Theodore M. King, Jr., MD 31. Date filed (Month Day Year) 10 State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of

29a Certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

death (Item 23a)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 2010 Mary Anna Guarino 4155 AM may Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner tizens Itarford Haure de Grace 8. Date of Birth
Jan. 18,1929 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Maryland 81 217-24-5961 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Marvland Cecil 1XXYes 2 No Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 345 Broad Street, Apt. 14 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) R.M.R. Corporation Elementary/Seconday (0-12) Nine Years College (1-4 or 5+) Assembly Line Laborer Elkton, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James T. Sadler Mabel M. Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
170 Linton Run Road, Port Deposit, Maryland 21904 19a. Informant's Name/Relationship (Type, Print) Lucille Price (sister) 1 and 2 s of Health item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Hopewell Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or 1 X Burial 2 Cremation 3 Removal from State 05/10/10 Port Deposit, Maryland 4 Donation 5 Other (Specify) Lee A. Partrerson & Son Funeral Home Perryville, Maryland 21903-0766 ture of Funeral Service License 21. Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Art Disease Can 040 nan Priyaidian disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes cate has been signated to be sould to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 🗌 Yes 2 🗎 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ျှ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32609 210 man 8110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kammicky Milham, Mod ince Revolution St Have De Grace Mod 21078

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Benow B. parks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2010 4:00p M Plma 6 May Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Chesapeake City 360 Biddle St. Apt. 8. Date of Birth
(Month, Day, Yea
Dec 28, Birthplace (State or Foreign Country)
 DE Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Hours 1919 DE 90 Yrs 221-05-5231 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State within 72 hours after death with the Maryland Director Chesapeake City 1 XYes 2 No MD Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21915 360 Biddle St. Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 X Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "na any injury or other traumatic event than "na once. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Small Business Owner Art Gallery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Anne R. Camburn George C. Kaehn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 Green Lane Newark, DE 19711 Barbara A. Gunther/ daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/13/2010 1 XBurial 2 Cremation 3 Removal from State Gracelawn Memorial Park New Castle, Delaware 4 ☐ Donation 5 ☐ Other (Specify) eral Service Licensee Name and Address of Facility T. Foard and 9 E. Main St. Gee Elkton, MD 21921 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final DIVATOV Physician/ disease or condition) Medical resulting in death) Due 1 Examiner 20 40 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Exam or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death ed by the a g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 Yes 2 No Yes 2 25 Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 \square Nursing Home 5 $mathbb{M}$ Residence 6 \square Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27 Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier apleted cause of deal (Item 23a) (Type, Print) 30. Name and address of person who co Elkton 32. Registrar's Signature State 0 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State		Certific	cate of	Death		R	eg. No.	
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year OCCO has								
Medical Examine	Joshua		eisbert				May 15, 2	2010	0629 hrs
	4a. Facility Name (if not institu St. Mary's Hospital	ne (if not institution, give street and number) 4b. City, Town, or Location of Death Leonardtown							f Death S
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year		_	rth (MM/DD/YYYY)	9. Birthplace (State or ForeignMinnesota
Director	217-11-3471	1 X M 2 F	26	Yrs.	Months Days	Hours Mir	07/30	/1983	Country)
an k	Usual Residence of Decedent 10a, State 10b, Coun	v	10c. City, Town	n or Locatio	n				10d. Inside City Limits
	N -1 1 0	narles	Ch	arlot	tet Hall				1 Yes 2 X No
daryland 28a-f show 1 at once.	10e. Street and Number				10f. Zip Code			Og. Citizen of Wha	at Country?
the Maryland a or 28a-f sho tiffied at once.	8700 Dubois	Road			20622			U S	5 A
with with be no be no stal	11. Marital Status	12. Was Dece	edent Ever in U.S.		Decedent of Hisps, specify Cuban,			14. Race - White,	- American Indian, Black,
r death with , or items 23 r must be no	1 Never Married 2	1 Yes	2X No		_		, , , , , , , , , , , , , , , , , , , ,		White
s after rral", niner	3 VVIdowed 4 1	Divorced If Yes, Give Year or Dates:			Yes 2 X No		work done	Specify: 16b. Kind of Bus	
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and 2.	Shirley Geisb	ert/Mother		of Disposit	ion (Name of cerr		Date	Hall, MI 20c. Location -	City or Town, State
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Division of Vital Records, P.O. ral or strending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled be refered.	examiner?	The second second	patient 2 🗸 ER/0	Jutnatient		of Death (Check Other Nursi		Residence 6	Other:
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Division or spital or Attending hours after death. narral Director: After y filled in by the fune. Certification:	4 Homicide	termined (Specify)	found	at re	sidence		St Mar	y s MD	
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			For State Registrar		e of Mary	/land / D	eparti		Health a				4	10	16	030
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and the same	Examir	er	4a. Facility Name (if not institution, g	ive street and	number)		4b	City, Town, or	r Location of	of Death		4		y of Death		
	/		FREDERICK MEMORIAL HOSPITAL FREDERICK FREDE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9.													
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36	", or	þ	1 Never Married 2 Marrie	d 1 🔼	Yes 2 No			Yes 2 ☑ No			,		Specif	ck, White	white	
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Baltimore,	ye 1a It of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal	from State		cremator	y or other plac	(e)		Date				Town, State	
Ë	t. Pag tmen trant: njury		4 Donation 5 Other (Sp		М	t. Oli		Cemeter	<u> </u>	5-7-2	2010	rec	leri	ck, M	larylan	.d
Bal	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Lig		1. 7	lene		me and Addres			Stauffe ike, Fr					21702
		-	23a, Part 1, Enter the disease, or co	omplications to	hat caused the	J	•						LICK	, riai	Approximat	
	Physician/		shock, or heart failure. List on Immediate Cause (Final	y one cause o	on each line.			CACT	INF						Interval Bet Onset and	Death
	Medical		disease or condition resulting in death)	a. Due	e to (or as a co			(1.01						\rightarrow	7110	No
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ŏ	ath c atten for u	ciar	in the past 12 months?		Live Birth 2 - Pregnant at tim			opic pregnanc er (specify)	у					onth	•	Year
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P.O.	ires that t signed b d be deta	oy P	Part II. Other significant condition	contributing	to death but no	ot resulting in	the under	ying cause giv	en in Part	1.				tribute to	the cause of d	eath?
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N.	al or A s after I Dire d in b		4 ∐ Homicide determin		uilding, etc. (Sp			,,			City or Tov					
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	2ga. Certifier 1 Certifying P													ınner stated.
	To the within 2 To the complex	ž	only one) 3 Certifying N 29b. Signature and title of certifier	urse Praction	ner: To the best	of my knowle	dge, death	29c. License	number		e, and due to the				Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 7, 2010 10:25 a Caldwell Gourley Medical County of Death
Montgomery a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. oct. 9, 1921 409-30-3080 1 M 2 F 88 Months Days Hours Country) T**ennessee** Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 520 Gilmoure Drive 20901 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the ! Secretary U.S. Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Robert S. Caldwell Sarah Lou Vaden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 520 Gilmoure Drive, Silver Spring, MD 20901 James S. Gourley/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis Oddreoffinis Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Physician Days Medical Due to (or as a consequence of) Examiner Days Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Aortic Stenosis years Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending ! IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo 5 Other (specify) Pregnant at time of death 1 Yes 2 1 9 Unknown Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 XXNo 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Other: 2 🔼 No 1 Npatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral discrete this filled in by the funeral dis 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 Natural
2 Accider 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa D32332 May 7, 2010

State Registrar 9801 Georgia Avenue, Silver Spring, MD 20902

of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Suresh K. Gupta, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3^{Day} Robert Samuel Hendricks Physician/ Menth 5 2010 1 Ρ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Middletown 4502 Deer Spring Rd. Apt. 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Countro 1 X M 2 □ F Months Days Hours Min 2⁴⁹14931 220-26-6072 79 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Frederick Middletown MD 1 Yes 2 No 10f. Zip Code 21769 10g. Citizen of What Country? 4502 Deer Spring Rd. Apt. 1 USA 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 \(\text{No.} \) No \(1952 \) 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural", 1954 Completed Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry int. Page 1 and 2 should be filed within 72 he artment of Health and Mental Hygiene. sortent: If teen 27 is marked other than "n. ortent: If teen 27 is marked other than "n. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) county Elementary/Seconday (0-12) College (1-4 or 5+) govt. mailman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Belle Crone George L. Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9812 Wandering Ln, Hagerstown, MD 21740 Greg Hendricks (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lutheran cemetery 5/6/2010 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Middletown, MD 4 Donation 5 Other (Specify) ral S ²Donald de B. Thompson Funeral Home POB 18, Middletown, MD 21769 21. Sign thre of I Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or leart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed Canae (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Live Birth 2 ☐ Fetal death 5 ☐ Other (specify) ____ IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the s Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 5 Pending Natural Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination allows investigation, in the second at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 5+WA 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayorth 5, 2010 Physician/ Year 6:20A. Sylvia Heiman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hillhaven Assisted Lvg. Nursing and Rehab Ctr. Adelphi 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Min. MaryTand 219-10-6165 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 🗆 Yes 2 No Woodstock Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2803 English Bond Court 21163 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes Give Specify. 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) the Secretary Legal Be 18. Mother's Name (First, Middle, Maiden Surname)
Bessie (unk) 17. Father's Name (First, Middle, Last) nd Mental H Harry Kellam and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2803 English Bond Court Woodstock, Maryland 21163 19a. Informant's Name/Relationship (Type, Print) S permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Randy Rachlin -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Judean Memorial Gdns 5/6/2010 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ADOLOCARCY MOMA THE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, OSTEOPOROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital 1 Yes 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending XNatural work?
1 Yes 2 No M Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) May 5, 2010 D55559 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #312 Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 10:30 PM April 25. **2010** Ada F. Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Chevy Chase Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 🕅 F 24,1915 Washington,D.C Director 94 095-32-1130 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County "natural", or Items 23a or 28a-f show adless Examiner must be notified at 1 TXYes 2 □ No Director None Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20012 6827 4th Street, North West Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after ☐Yes 2☐No Yes, Give 1 □ Never Married 2 □ Married African 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: Specify. by If Yes, Give Year or Dates 3 to Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government Parol Officer 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event Be Celeste Horner Charles Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6827 4th Street, North West, Washington, D.C. <u>Deborah E. Reeves/Goddaughter</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | May 7,2010 | Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service 7400 Georgia Avenue, N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** /Medical Due to (or as a consequence of): Examiner congentin Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burlal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical signed by the attending to be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Dav in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page pertormed after death.

Director: After this certific
I in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation **∑** Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide filled 24 hours a Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10054566 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Grangia Avnu # H7, Silverspring MD 20902. Sunitho Bho gaville Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 06 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Cen	tificate o	f Death		R	eg. No.	
Physicia	ın/	1. Decedent's Name (First, Midd						2. Date of Dea Month		3. Time of Death
Medical Exami	ner	David Michae						May 4, 20	10	1502 hrs
		4a. Facility Name (if not institution Calvert Memorial Hos	· -	umber)		4b. City, Town, o		Death	4c. County of E	Death
Funeral	4	5. Social Security Number								
Director		216-33-3350	1 ※ M 2□F		20 Yr	Months Da	ys Hours		/1989	oreign Country) Maryland
è		Usual Residence of Decedent 10a. State 10b. County		Inc. City	Town or Loca	tion				10d. Inside City Limits
_ &										1 Yes 2 * No
rylanc a-f sh	흕	Maryland Cal	vert	St.	. Leona	10f. Zip Code			0g. Citizen of What	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	2730 Vivians Wa	ay			20685	5		United St	
h with	Funeral	11. Marital Status 1 % Never Married 2 M	_	cedent Ever in U.S				? (Specify Yes or No uerto Rican, etc.)	- 14. Race - A White, e	American Indian, Black, etc.
fter deat			1 Yes	2 💥 No	1		specify:	,	Specify:	White
ours a	d b	15. Decedent's Education (Spe	or Dates: ecify only highest gra	ade completed)		nt's Usual Occupa			16b. Kind of Busin	ess/Industry
oal Ey	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)	_	nost of working life	e. DO NOT us	se retired)		
within iene.	ompleted		2		Stud	lent			College	
filed of the truth	ပ	17. Father's Name (First, Middle David Wayne Kr						Name (First, Middle, I y1 Lynn Th	•	
212 ald be Menta mark	o Be	19a. Informant's Name/Relations			19b. Mailin	g Address (Stre		er or Rural Route Num		State, Zip Code)
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumartic event, the Medical		Cheryl L. Krank		Mother		•		St. Leonar		
e, North and Health	ı	20a. Method of Disposition			lace of Dispos	sition (Name of ce	emetery,	Date	20c. Location - Ci	ty or Town, State
nor Pages ent of mt: If		1 Burial 2 Cremation 4 Donation 5 Other S		TOTTI State		an Cremato	rv	05/06/10	Alexandri	a, Virginia
Baltin permit. P. Departmer Importan	ŀ	21. Signature of Funeral Service		. ()	22. 1	Name and Addres	s of Facility	Rausch Fu	neral Hom	e, P.A.
E.E.P.B.	d	michael Yever	Hardin	in the	F	0.0. Box	600, I	Lusby, MD	20657	Ü,
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused he death.	Do not enter t	the mode of dying	, such as card	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
i I Examiner	İ	Immediate Cause (Final disease or condition resulting in death)								Death
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of)	ï					
uted nd ransit	ŭ	events resulting in death) Last	d	,						
760, cate be executed physician and the burial - transi	Medical	UNPENDED	AMENDED	-						
	Š	IF FEMALE: 23b. Was decedent pregnant in the	20	outcome of pregn	ancy				23d. Date of del	
Sox 687 death certific e attending for use as t	sician	past 12 months?	I I TIME	birth nant at time of dea	_ = =		Ectopic pr	regnancy	Month	Day Year
Box 68 e death certif	ysic	1 Yes 2 No 9 Uni	known 9 Unkr		5 [] O	ther (Specify)				
ords, P.O. B w requires that the d s been signed by the should be detached	, Phy	Part II. Other significant condit	tions contributing t	to death but not re	sulting in the	underlying cause	given in Part I			e to the cause of death?
ires th	ğ Ş							1Yes	2 No 3	Probably 4 Unknown
ords v requ	lete	í						24a. Was autop		re autopsy findings available r to completion of cause of
Pre lav	Completed			-				perfor	med? deat 2 No 1 ✓	th? Yes 2 No
Vital Rec ysician: The l his certificate l director, page	BeC	25. Was case referred to medica				26.Plac		heck only one)		
Vit.	일	examiner?	Hospital: 1	Inpatient 2 🗸 I						Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the state death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacd.	崩	27. Manner of Death 1 Natural 5 Page	28a. Date May 4	b Day Year)	28b. Time of I 1410 hrs		ury at Work?	Driver auto :	now injury occurred auto collision	
Sior Attend death ctor: y the	ij	Pend	stigation				Yes 2 V No			
Division ospital or Attenchours after death meral Director:	Certification:	dete	id not be	ce of Injury - At ho		et, factory, office	building, etc.	or Town, S	tate)	r Rural Route Number, City own Road, Hughesville,
ospital o hours a uneral I		4 Homicide	1-5	Local Stree	_	erad at the time of	late and place	, and due to the caus		
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Orlock City)	miner:On the basis	of examination an				red at the time, date		
To vit	Me	29b. Signature and title of certifie	and manner	stated.		29c. Licen:	se number		29d. Date signed	(Month, Day, Year)
		Marianto B	re Chill			O.C.	M.E.		May 5, 2010	
(1) 5		30. Name and address of person	who completed cau	use of death (Item 2	23a)	1				
JEW 5	9	Margarita Korell MD.	Assistant Me	dical Examine	er 111 P	enn Street, B	Baltimore, N	MD 21201		
	ate	31. Date filed (Month, Day Year)		egistrar's Signatur	h hon	aked				
Regist	rar	MAYO	7 2010 🔏	energy p	s. 149 a	File spread				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 May Physician/ King 10 4:30 A.M Dona1d Genoa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Asbury-Solomons Health Care Solomons If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** April 10,1917 1 🕅 M 2 🗆 F Mary Land 212-10-3933 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Funeral Director 1 Yes 2 X No MD Solomons Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 11750 Asbury Circle Room 241 20688 ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 K Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: white Specify 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "naturury or other traumatic event, the Medical Iury or other traumatic event, the Medical Is 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) advertising 12 salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Phillip King Emma Jane Lvdard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2825 Beach Drive, Huntingtown, MD Sandra King Geest, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/10/2010 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. . Sign ur of Funeral Service Licensee American Lane, Lusby, MD 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DUSFASE Y PARI ALZHERMER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 14 No 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 🖰 No 4 Aursing Home 5 Residence 6 Other (Specify) ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death,

To the Funeral Director: After this completed filled in by the funeral dir DVM

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

and

physician

attending

certificate

director,

for

within 72 hours after death with the Maryland

than "natural",

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

JOH-31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

MEIGEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖵 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

		-	For State Registrar		State of N	ıaryıar			of Heal		Mental Hy	giene Reg. No	201	0	16037
	Physicia	ın/	Decedent's Name (First,	Middle, La	ast)						2. Date of De	eath Da	av Yea	ır	3. Time of Death
j	Medic	al	Afrouz Khai 4a. Facility Name (if not ins					4h City	Town or Loca	tion of Death	May 3 ,		. O c. County of De		11:40am ^M
-	Examin	er	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital Rockville						alon of Boda			Montgo		7	
	Funeral Director		5. Social Security Number 007-82-9297	6.			last birthday) Yrs.	If Under Months	1 Year If U Days Ho	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da April 2	rth a <i>y Year)</i> 25 , 1		Birthpla Co <i>untry,</i> ran	ce (State or Foreign)
	how at	ř	Usual Residence of Deced 10a. State 10b. 0	ent County		10c. Cit	ty, Town or Loc	cation						10d	I. Inside City Limits
	farylar 8a-f s tified	Funeral Director	Maryland Mo	ntgom	erv	Bur	tonsvi	11e							1 ☐ Yes 2 🔀 No
	the N	٥	10e. Street and Number	21080		1		10f. Zip	Code			10g. Ci	itizen of What	Country	/?
	h with	nera	15214 Lions	Den R					20866				ted St	ates	5
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fu	11. Marital Status 1 ☐ Never Married 2 3 ☒ Widowed 4 ☐ Di		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S No	l1	f Yes, speci	ent of Hispani ify Cuban, Me 2 X No Spe	xican, Puert	pecify Yes or No- o Rican, etc.)	-	14. Race - Ar Black, Wi Specify: W	hite, etc	b.
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Maryland	be filed antal H ked ot	To Be	17. Father's Name (First, M Nosrat Khai								_{ne (First, Middle,} Khairkh		Surname)		
ary	hould I and Me s marl umati		19a. Informant's Name/Re				19b. Mailin	g Address			ral Route Numbe		r Town, State,	Zip Cod	de)
Σ	nd 2 sł ealth a m 27 ii ner tra		Bahman Neko		(Son)		40 C	ottag	e Park	Road,	Port1a	nd,	ME 041	03	
Jore	ge 1 and the street or other		20a. Method of Disposition 1 🔣 Burial 2 🗋 Crer	mation 3 [☐ Removal from Stat	e C	Place of Dispo cemetery, cren	natory or ot	ther place)		Date		ocation - City		
Baltimore,	nit. Pa lartmel lortant lnjury		4 Donation 5 0			Pa	rklawn	Memo:	rial Pa	ark 5/	6/2010 Vol Fun	Roc era1	Home	, Ma	aryland
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9	Medical Examiner		resulting in death)	ſ	Due to (or as		,								5 Years
^		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	s, te	b. Due to (or as										
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Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, Hert this certificate has been signed by the attending physician and Funeral Director, the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 🔀 No 9 ☐ Unknown		23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 L Feta at time of	al death 3 🖳	Ectopic p Other (spe		<u>-</u>			23d. Date of Month	delivery Da	ay Year
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ords	require been si should	letec									24a. Was		24b. Were	autopsy	findings available
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tal	sician; The certificate rector, pag	Be C	25. Was case referred to m examiner?	edical	Hospital:					Death (Chec					
f Vi	Physic this or	은	1 Yes 2 X No		1 🗵 Inpa		ER/Outpatien		Other: 4 [3c. Injury at	Nursing H	ome 5 Resi			ecify)	
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_	To the Hospital or within 24 hours after To the Funeral Directory completed filled in the total of the total	Medical	(Check 2 I Me	dical Exan	ysician: To the best on niner: On the basis of irse Practioner: To the	examinatio	n and/or invest	igation, in n	ny opinion, dea	ath occurred	at the time, date a	and place	e, and due to th	ne cause	e(s) and manner stated.
	with to a		29b. Signature and title of	Certifier (h			29c.	License numb	ber 8// Z	_		nte signed (Mo		1, Year) 2-0/01
	7		30. Name and address of p	erson who	·							0050			
	-01-		Daphne Keshi 31. Date filed (Month, Day,						ve, Ro	ckvill	e, MD 2	0850)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16038 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 5 Year Physician/ Kelly 2010 4:35 A Martha Mary Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Rockville Montgamery Montgomery Hospice Casey House 9. Birthplace (State or Foreign Country) South Carolina If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)
April 25, 1 □ M 2 □ F Months Days Hours Min. 249-76-0931 66 Carolina **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 28a-f sho Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Hyattsville Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20781 USA Funeral 6305 Riggs Road #117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Black 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 6th College (1-4 or 5+) Private Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Beatrice Super of Health and Menta fitem 27 is marked rother traumatic e Helene Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6305 Riggs Road #117, Hyattsville, MD 20781 Curtis Kelly (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/12/2010 Heritage Mem. Park Waldorf, Maryland Signature Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End Stage Liver Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? nas certificate ha performed 1 Yes 2 No 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 2 🔀 No ၉ 1 Yes this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work?
1 Yes 2 No 1 X Natural 5 Pending death. ☐ Accident ☐ Suicide Investigation
6 Could not be s after death | Director: / d in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville MD 20855 CNP Diane Ruckert, 1 0 2010 32. Registrar's Signature State

Registrar

		Aı	Please Type or Print in E mend 23a, 28d, per M Eg 905 7/13 State of Maryland	Black In 710 T 7 Depa	delible Inlartment of H	c. Ensure A lealth and N	II Copie 1ental Hy	s Are Le	gible.	6039
		1	State Registrar		tificate of L			Reg. No.		
			Decedent's Name (First, Middle, Last)				2. Date of De			ime of Death
F	Physicia		William Franklin Longle	ey. Jr			Month May	6,	2010 5:	40 a. M
	Medic Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. Coun	ty of Death	
			25565 Jimmy's Lane		Hol:	lywood		St.	. Mary's	7 6 6
	uneral irector		5. Social Security Number 6. Sex 15 M 2 \square F 7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08/02/	1964	9. Birthplace (Country) Ma	State or Foreign aryland
	Mo.		Usual Residence of Decedent							
/land	fshc	흱	10a. State 10b. County 10c. City,	, Town or Loc	cation					side City Limits
Mar	28a- otifi	ie	Maryland St. Mary's	Holly						Li Yes 2 Li No
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dear	r iter iner		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	14. Ra	ace - American Inc ack, White, etc.	lian,
36 after	al", o	d b	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 7 Pates	1	☐ Yes 2 🔀 No	Specify:		Speci	^{fy:} White	
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212 Within	ar the	ပိ	11	Heavy	Equipme	nt Operat	or	Cons	truction	
D Delle	vent,		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surnai	me)	
/ ar	arked itic e	유	William Franklin Longley			Doris	Jean	Rober	tson	
Maryland 21215-0036 2 should be filed within 72 hours after	is ma	l	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura				
Z 24	n 27 er tra		Lisa Longley/Spouse	P.0	D. Box 62	21, Holly	wood, M	D 20636		
ore Terminal	fiter roth		20a. Method of Disposition 20b. Pl 1 🛣 Burial 2 □ Cremation 3 □ Removal from State	ace of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location	n - City or Town, S	tate
Page Fage	ant: I		La bullar 2 - Oremation 5 - Hemovarion ctate		Peace		1/2010	Helen	, Maryla	nd _
Baltimore,	Department or neutin and wentlar prygene. Impartment or neutin and wentlar prygene. any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servicens			ss of Facility \mathtt{Bri}				
m % & & & & & & & & & & & & & & & & & &	2 = 2 9		Edward N. Brinsfield, Jr. MOO						m, MD 20	650
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rds, P.O.	signed by	d by Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.		tobacco use co	ntribute to the cau	
Division of Vital Records, all or Attending Physician: The law requires enfant chant.	peen	ete					24a. Was	an 24t	o. Were autopsy fir	ndinos available
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Sio	ctor:	E	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, stre					nber or Rural Route	
N in	Dire d in t		building, etc. (Specify)			ļ	City or To	wn, State)	TIMEN	tollywire
Spita	within 24 rough area or and in the funeral blast conflicate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death o	occured at the time	e, date and place, ar	nd due to the c	ause(s) and ma	nner as stated.	
e Ho	le Fu	Ved	(Check only one) 3 Certifying Nurse Practioner: To the best of my							and manner stated.
To th	To the	-	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sign	ned (Month, Day, Y	(ear)
			1 MIL Strait)	D0	14285		May 6	2010	
			30. Name and address of person who completed cause of death (Item		Print)					
pme						kout Rd.,	Leonar	dtown,	MD 20650)
	Sta Registra	_	31. Date filed (Month, Day, Year) NAY 1 3 2010 A. Registrar's Signat	par	KN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, Physician/ 2010 Herald Lazaroff 5:03 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Yea
Aug 18, Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F Months Days Hours Washington. **Director** 579-26-5465 84 Aug Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11513 Lockhart Place 20902 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces?

X Yes 2 □ No 1943 Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Completed 3x Widowed 4 □ Divorced 1945 White Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) Callege (1-4 or 5+) Salesman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be find Health and Mental item 27 is marked ည Louis Lazaroff Ann Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joy Lazaroff/Daughter</u> other 1 706 Kenbrook Drive, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 Cremation 3 Removal from State Judean Memorial Grd\$ May 4,2010 01ney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addres Danziansky-Goldberg Memorial Chapels Inc 1170 Rockville PIke, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee M01597 MWWMelissa Greenhut 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Coronary Artery Disease Sequentially list conditions Examine Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Fibrosis the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No ned by the a Yes a 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be d 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? Yes 2 🔀 No certificate 1 ☐ Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 24 hours after death.

Funeral Director: A Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D0067355 May 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) **MAY 0 6 2010**

Daniel Shirk, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910

			For State of M		epartment of He Certificate of D			giene 0 1 0	6041
	Physicia	an	1. Decedent's Name (First, Middle, Last) Gerald A. McElw	ain			2. Date of Dea Month May	th Day Yeer 18 2010	3. Time of Death 8:16P ^M
	/Medic Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	Hay	4c. County of Dee	th
100	Funeral Director		Sunshine Acres Rehabilit 5. Social Security Number 219-36-0496 6. Sex 1 M M 2 D F	cation Ct ge (In yrs. last birthd 88 Yrs	Months Days	e Hall If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 19	Harfo (, Year) 9. Bir () 1921 M	ord thplace (State or Foreign ountry) Maryland
	D		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		ing v 23	7 - 3 - 3	10d. Inside City Limits
	a-1 eh	ctor	MD Harford	Wh:	ite Hall				1 ☐ Yes 2 X No
	vith the	Dire	10e. Street and Number		10f. Zip Code	1161	1	10g. Citizen of What C	ountry?
	eath v	erai	5025 Carea Road 11. Marital Status 12. Was Deceden	t Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cubar	1161 spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Interpretation of Health and Mental Hygiene. The Maryland Examiner maint be nicitied at any injury or other treumatic event. The Maryland Examiner maint be nicitied at an and once.	by Funeral Director	Armed Forces 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ 3 □ Widowed 4 □ Divorced Year or Dates	No	If Yes, specify Cubar	Specify:	Hican, etc.)	Specify:	white
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מוומע	a filed al Hygi other	Be Cc	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
ylal	Menta Menta marked	To	Allen R. McElwain				l Jenk:		Tie Codo)
Ma	d 2 sh th and th and treum		19a. Informant's Name/Relationship (Type, Print) Doris G. McElwain		Mailing Address (Street a				
ָט מ	s 1 and Heal item 2		20a. Method of Disposition	20b. Place of D	isposition (Name of		Date	20c. Location - City o	
Dallillor	Page ment o ant: If ury or		1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Presbyt	crematory or other place entre erian Cemet	ery may .	22,2010	New Park	PA
Dall	permit. Depart Import eny inj		SI Signature of Funeral Service Licensee	stein the					Mortuary Inc own, PA 17363
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DIVISION	after deal Director	Certification:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farmetc. (Specify)	n, street, factory, office		28f. Location (S City or Tox	Street and Number or I vn. State)	Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the besis and manner:	of examination and/	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and manner added	as stated. ue to the cause(s)
	To the within :	Mec	29b. Signature and little of certifier		29c. Licensi	e number		29d. Date signed (Mod	
			Chas MD			55025		5-19	- 2010
2	01	Annual Control of the	30. Name and address of person who completed cause of	death (Item 23a) (T	ype, Print) 2d Neu	v Freedo	n PA	17349	
	Sta	ate	21 Date filed (Month Day Year) """ 32. Rest	macs Signature		,, 0,00		7.1	
	Regist		RAY 2 1 2010	was M	how that				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year QOO Month Physician/ 04.10 AM Mildred Harkness Mitchell Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner grace Har de Hause 101 Home Citizens NUISINA 8. Date of Birth (Month, Day Jan. 19 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday Funeral 1 □ M 2 🎗 F Hours Maryland ^{ear} 923 217-12-3166 87 Jan. Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 1XXYes 2 ☐ No 28a-f Harford Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral "natural", or items 23a 900 South Adams Street 21078 U.S.A. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XXNo δ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Aberdeen Proving Ground 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Aberdeen, Maryland Occupational Nurse and Mental Hygie is marked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Milcred E. Nicholes James John Harkness 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 South Adams Street, Havre de Grace, MD 21078 Mildred Ann DiGiovanni Department of Health Important: If item 27 Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Angel Hill Cemetery 20c. Location - City or Town, State Havre de Grace, 20a. Method of Disposition Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/12/10 Maryland Partiers of Facility
Pe A. Patterson & Son Funeral
Perryville, Maryland 21 21. Signature of Funeral Service Licen 'n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to or as a consequence of: Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lot as Exami neuminia that initiated events resulting in death) Last trar Due to (of as a consequence of): attending physiclan for use as the buria Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregpant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Pregnant at time of death Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 2 🛮 No certificate 1 🗆 Yes Yes 25. Was case referred to predical Division of Vital 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 PNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 3 MID

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/01/2010 1453 NELLIE MILLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Country) Puerto Rico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours Min. 1 □ M 2X F Months Director Yrs <u>092-28-2524</u> Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20850 14201 Arbor Forest Drive, #301 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █XNo 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify: Hispanic If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Hispanic the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Consumer Affairs Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marina Lopez Geraldo Matos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 s Health 5158 Abuela Drive, San Diego, CA 92124 Laura Miller Smith - daughter other 1 Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/4/10 4 Donati 5 Other (Specify) Ardent Cremation Sv Hanover, MD 22. Name and Address of Facility Funeral Service Licens Snowden Funeral Home 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit that the death certificate be executed Exan that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Physician: The law requires Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 (XNo 1 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ë After Hospital or Attending X Natural 5 Pending Certifical 1 Yes within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) To the 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) 10 D45880 5/1/10 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Leon Hwang 1396 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

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Bullo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Edith Deloris Hunter Patterson 0110 0.5 2010 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** COY 8. Date of Birth (Month, Day, Year) April 23, 1939 9. Birthplace (State or Foreign Country) GA **Funeral** Months 1 □ M 2 🛣 Days Hours 71 262-50-7546 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Wicomico Salisbury MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 USA 833 Victoria Park, Apt. 111 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes 2 XNo Black, White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, 1 Yes 2 No Specify American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Restaurant Hostess Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Marie Timmons Levi Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nadine Jones/daughter 1209 Shawnee Avenue, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Green Acres
Memorial Park 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/2010 Salisbury, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Signature of Funeral Service Licensee Walson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AJCU D Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 욘 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 X Natural 5 Pending 1 Tes Accident Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Cattifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title DME 45045) no completed cause of death (Item 23a) (Type, Print) 21801 100 E Carroll wo Salishung 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Samuel Pizer May 3, 2010 10:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year I if Under 24 Hrs 3665 South Leisure World Blvd. Montgomery Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Social Security Number Hours **Funeral** Days 1**☑** M 2□ F Jan 2, 1919 England Director 91 132-03-8056 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1√1Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Silver Spring 3665 South Leisure World Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 Divorced tal Hygiene. d other than "nature event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental int; If item 27 is marked o permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked, any lijury or other traumatic evonce. Alfred Pizer Hannah Cushman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 217 Normandy Drive, Silver Spring, Maryland 20901 Gerald L. Pizer, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 X Cremation 3 X Removal from State 05/04/2010 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, MD 20852 M01255 1170 Rockville Pike, Rockvi
23a. Parth Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1255 1170 Rockville Pike, Rockville, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Arteriosclerotic Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Arteriosclerotic Cardiovascular Heart Disease 1 Tes 2 No 3 Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Carcinoma of Prostate page 2 s autopsy performed? Failure to Thrive Syndrome 1∐ Yes 2 No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death the 1 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 3, 2010 D0055522 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland Robert H. Gerard, MD, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2010 5 NO CH 9:30 AM ANIC May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery 01ney 8. Date of Birth
Dec. 4, 1935 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign ocial Security Number last birthday) **Funeral** Hours Days Min. 325-28-8454 Months 1 □ M 2 🗓 F 74 Massachusetts Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Silver Spring Maryland Montgomery 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20906 3158 Adderley Court, APT 242B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Important: If item 27 is marked othe any injury or other traumatic event, Be 1 and 2 should be theu of Health and Mental H fitem 27 is marked of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alice Conway Francis P. Lowrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 West Brother Drive, Greenwich, CT 06830 Chris Poch (Son) permit. Page 1 and 2 Department of Healt Important: If item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) George Washington Cemetery 1 A Burial 2 Cremation 3 Removal from State May 8, 2010 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 21. Signatule of Fundra Sérvice Lic ensee MD 20877 10 East Deer Park Drive, Gaithersburg, M00689 Part JEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thiknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? THROMBOCYTOPENIA 24a. Was an autopsy certificate has performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation completed filled in by the Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D005 M.D. Anuradha Arun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#17, 18perINF, 5/17/10, BMW, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 0715 Betty Popkin 2010 122 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nursing Examiner Spring Montgomery Brooke Grove Rehabilitation and center Dandy 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Washington, DC 1 🔛 M 2 😾 F Hours Jume th 300, Year 915 94 579-14-4102 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland aţ Director be notified 1 Yes 2 No Sandy Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Numbe 23a Funeral 20860 United States 18100 Slade School Road **Examiner must** items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc o. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 X Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elemenary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)

Pagadia Tologo Bessie Hayman 17. Father's Name (First, Middle, Last) Nathan Tolstoi Michael S. Ponkin 1 and 2 should to of Health and Me item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3384 Hewitt Avenue #301 Silver Spring MD 20906 19a. Informant's Name/Relationship (Type, Print) Susan Popkin Wilcox - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XBurial 2 Cremation 3 Removal from State 05/06/2010 Judean Memorial Grdns Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO116323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician acute myocardial MINUTES Medical resulting in death) Due to (or as a consequence of) Examiner oronary. artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for selective guence of) and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes_2 No 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certificate I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier ٥ D42046 attending ohysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brookett Ffman H.D. 18100 Stade School Road Sandy State 6 Registrar

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 10, 2010

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

du

gistrar's Signature

29b. Signature and title of certifier

Carol Allan, MD

31 Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2<u>010</u> Month MAY Physician/ 0:50A WILLIAM RAMSBURG JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, **Funeral** Months Days Hours 1 ★ M 2 □ F Maryland 214-10-5914 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director TX□ Yes 2 □ No Frederick Maryland Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21703 U.S.A. 301 Braddock Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Welding & Radiator 12 Owner & Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret D. Bowers William L. Ramsburg, Sr. and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10328 Old Annapolis Road, Walkersville, MD 21793 M. June Ruffner / Daughter . Page 1 and 2 siment of Health a tant: If item 27 i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 5/6/2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses RÖBERT^{IND}AGGER & SON FUNERAL HOMES, P.A 1201 NORTH MARKET STREET, FREDERICK, MD 2 MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year g 🗌 Unknown the 9 Unknown signed by: 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 M No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opening, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054636 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Frederick MD. 21701 SYED HAQUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 19a per KH g903 5/21 Gertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2050 Somerville **Physician** -08-2010 Kence 4mia /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cheverl Prince George's Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🗹 F 04-08-2010 Mary Land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "house I Examiner must be notified at 1 Pres 2 No Director MI nce 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 3008 20706 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE -ntANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Britmey Un Known ပ 19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brittney M. Seaborn 3008 Brightseat Rd#101 Lanham MD

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or To 20706 mother 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ▼Other (Specify) HOSPITE! Cheverly, MD Hosp Georges 22. Name and Address of Facility Arince Georges Hospital 21. Signature of Funeral Service kice 20785 cheverly Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final eterm Delivery at 22 Week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHORIOAMNIONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Premature Rupture of Membranes nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Preterm resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, CEVUIX Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ned by the a detached f 1 ∐Yes 2 12No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, sign 1 be 2 No 3 Probably 4 Unknown 1 □ Yes been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has lirector, page 2 s 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No ours after death. leral Director: Ai filled in by the fu 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL Drive Cheverly, MD 20785 Powell-Davis 3001-Registrar's Signa State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ${\tt May}^{\sf Month}$ Year Physician/ 20°10 6 11:10 A M Μ. Shockley Wanda Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Min. 2-21-1923 Hours 1 □ M 2 🛛 F Maryland 218-16-8527 87 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21804 USA 30586 Zion Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ò 1 Never Married 2 K Married ☐ Yes 2 🛛 No Manda Shock Ley Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White Specify: If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker q Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
r traumatic even ٩ Rachel Dillahay Carl Darby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 30586 Zion Road, Salisbury, Maryland 21804 Gorman Shockley - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 5-10-2010 Springhill Memory Gd : Hebron, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 7. Enter the disease, or complic shock, or heart failure. List only on cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Due to for as a consequence of Examir and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed 1 Yes 2 No ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28c. Injury at work? 1 🔲 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending I hours after death. uneral Director: Aft ed filled in by the fur 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 910 Easternshore Dr Salisbury MD Mahesha Thimmarayappa M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 07 Registrar

Christopher Anders	1- For State Certificate of Death						
Physician <i>l</i> Medical Examiner	Christopher Anderson Shifflett	Date of Death Month Day May 3, 2010 3. Time of Death 1708 hrs					
j	4a. Facility Name (if not institution, give street and number) 5426 Laurel Trail 4b. City, Town, or Location of Death St. Leonard	4c. County of Death Calvert					
Funeral Director	219-21-1374 1 M 2 F 27 Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 08/30/1982 Fine gray Land Sounty)					
the Maryland or 28s-f show any iffied at once. Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 20685	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	ify Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc. Specify hite					
5-0036 led within 72 hours yegiene. other than "natur the Medical Exam Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Contstruction						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Cleta Mi.						
MD 21 nd 2 should alth and Me in 27 is ma aumatic er	19a. Informant's Name/Relationship (Type, Print) Roy C. Shifflett father 19b. Mailing Address (Street and Number or Rura 5426 Laurel Trail St. I	Leonard MD 20685					
Baltimore, permit. Pages I an Department of Hee Important: If iten injury or other tr	1 Burial 2 Cremation 3 Removal from State Metropolitan Funeral Service 4 Donation 5 Other Specify:	Alexandria Virginia					
Physician		. Port Republic MD 20676					
Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and Death					
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.						
executed an and al - transit	events resulting in death) Last Due to (or as a consequence of): d.						
e e e	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery					
Sox 68 leath certif e attending for use as	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of fleath 9 Unknown 5 Other (Specify)	y Month Day Year					
ords, P.O. E w requires that the d is been signed by the should be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
Division of Vital Records, tal or Attending Physician: The law requires as after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed		24a. Was an autopsy autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No No					
F Vital F Physician: 'Physician: 'ar this certifis ard director. To Be C	25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Nursing H						
Division of Papiral or Attending Phones after death. Per Director: After If filled in by the funeral filled in by the funeral Certification: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	d. Describe how injury occurred ibject hanged self					
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune ledical Certification:	Accident investigation investi						
To the Hos within 24 h To the Fur completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.						
M A	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 4, 2010					
Jew 1	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201					
State Registrar	31. Date filed (Month Pau Year) 32. Registrar's Signature						

DHMH 17 Rev 1/2001

0-03429 Iohn Stratchko		Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental H	es Are Leg Ivaiene	jible.	1000
	F	1- For State Certificate of Death		g. No.	16053
Physicia Medical Examin	n/		2. Date of Death Month May 3, 201		3. Time of Death 1924 hrs
		4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital 4b. City, Town, or Location of Death Prince Frederick	h	4c. County of Dea Calvert	th
Funeral Director		213-23-7301 1 x M 2 F 21 Yrs. Months Days Hours Mir		C	rthplace (State or Foreign ountry) aryland
te Maryland or 28a-f show any fied at once,	Director	Usual Residence of Decedent 10a. State	10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No untry?
ith the Ma 23n or 29 notified		3985 Island Creek Lane 20615 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	inecify Yes or No-	United St	ates rican Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Stant: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced or Pates: If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No 1 Yes 2 X No specify:	o Rican, etc.)	White, etc.	ite
036 ithin 72 hours ne. r than "natus fedical Exam	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Student	tired)	college	Anaustry
1215-0 I be filed w ental Hygie arked othe	Be	James A. Stratchko Alesia	e (First, Middle, M Forehan	.d	7:- 0-4:)
MD 2 nd 2 should alth and M m 27 is m	ို	19a. Informant's Name/Relationship (Type, Print) James Stratchko – father 19b. Mailing Address (Street and Number or 3985 Island Creek Lan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, May	e Broome	-	ID 20615
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State Chesapeake Highlands Mem. 4 Donation 5 Other Specify: 21. Signature of Funerary Service Licensee 22. Name and Address of Facility Ray 4405 Broomes	Gardens	Port Repu	ıblic Marylan
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.			Approximate Interval Between Onset and
//Vedical Examiner	İ	Immediate Cause (Final disease or condition resulting in death) a. Multiple Blunt Force Injuries Due to (or as a consequence of):			Death
od Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
execu an and al - tra	<u>s</u>				
	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ancy	23d. Date of delive Month	ry Day Year
P.O. Is that the greed by the detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Pro	
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al R	BeC	25. Was case referred to medical 26.Place of Death (Check			
f Vit Physic er this c	은	1 Ves 2 No Page of Death 128a Date of Injury 128c Injury at Work?		Residence 6 Other	er:
sion o ttending death. etor: Aft y the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury May 3, 2010 Year) 28b. Time of Injury 28c. Injury at Work? 10000 hrs 1 Yes 2 No		cycle pick up true	
Division Bospital or Attend 24 hours after death. Funeral Director:	ertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street			tural Route Number, City ne, Brooms Island, MD
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Medical C	(Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date a	and place, and due to t	he cause(s)
	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M May 4, 2010	onth, Day, Year)
drw 6		30. Name/and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	ID 21201		
				OCME	
				OVITIE	

DHMH 17 Rev 1/2001 OCME 2006

10-03429

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** Stackhouse 103 AM iolet Mac 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick) alue Memoria lalvet POSPILE If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 178-09-4295 92 Director 10/28/1917 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, It a finalist Examiner must be notified at 1 ☐ Yes 2 🕱 No Director Maryland Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3861 Sunrise Drive 20639 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🕱 No Specify: þ White 3 X Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Florida County Courts permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygir Important: If Item 27 is marked other 1 any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Kolanko Helen Krawczyk Kolanko ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wynne Maksimovic / Daughter 3861 Sunrise Drive, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 05/07/2010 Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Sary J. Goff 8125 Southern Maryland Blvd., Owings, MD 20736 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lespiration Faile /Medical Due to (or as a consequence of): Examiner Kight Sid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a d be detached for ∐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown)ementio Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation s after deau ral Director: Aft 1 Natural 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours To the Funeral To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 6,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW Horpita MO 00 32. Registra Signature 31. Date filed (Month, Day State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2:17 pm Claudia Marisol Salazar May 03 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 3702 May Street Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours 0972471971 El Salvador Director 213-49-3066 38 Usual Residence of Decedent 2 should be filed within 7.5 incomes. In and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show its marked other than "edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3702 May Street 20906 El Salvador Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married \$ Maryland 21215-0036 1 K Yes 2 □ No Specify: Salvadorean If Yes, Give Specify: 3 Divorced Completed Caucasian Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineer Apartment Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Carlos Alberto Argueta Ana Gladys Montalvo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luis S. Salazar - Spouse 3702 May Street, Silver Spring, Maryland 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Gate of Heaven Cem. 05/07/2010 Silver Spring, MD ture of F mera Service Li ensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Sign M00709 1800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. 23a. Part 1. Ent Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Breast Cancer uears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Injurithat initiated events resulting in death) Last and-tran-Due to (or as a consequence of): physician the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 No this certificate has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' Hospital Other 2 X No 1 Tes ုဂ္င 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify Director; After the in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 X Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after determined within 24 hours after To the Funeral Directornoleted filled in b Hospital Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 respons May 5, 2010 D23308 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

6420 Rockledge Drive, Suite 4100, Bethesda, Maryland 20817

MD.

31. Date filed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:30P M Smith Jean Oliver 4 010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 XM 2 . F Days 578-34-7119 81 ,1928 **Director** <u>Sept</u> Washington, D.C. Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State be notified at Director Silver Spring MD Montgomery 1 X Yes 2 No 10f. Zip Code ò 10e. Street and Numbe 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 20904 11381 Columbia Pike Apt. A2 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes, Give 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 1951 "natural", Completed 3 Widowed 4 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) House Painting Painter 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Christopher Smith Taylor William Anna 1 and 2 should E f Health and Mei tem 27 is mark Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 381 Columbia Pike Apt A2 1ver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Evelyn Rain Smith/Wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Waşh. Un Cent **University** 4 Donation 5 Other (Specify) Washington, D.C. 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Respiratory Failure Days Medical resulting in death) Due to (or as a consequence of) **Examiner** Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ш burialattending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Yes 2 No 9 Unknown Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sepsis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Failure page 2 s performed's 2 🗆 No certificate Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: ပ္ 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License numbe May 4, 2010 D32332 VIXA

Registrar

avend

9801 Georgia Avenue Suite 220

Silver Spring, MD 20902

s of person who completed cause of death (Item 23a) (Type, Print)

Gupta, M.D.

Suresh\K.

MAY 06 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 20ĬÔ 04^{ay} 9:05 Sullivan p Cornelius Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Aspenwood Senior Living Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Number Funeral 157-14-2475 1 X M 2 🗆 84 Months Days Hours Min Nov 05, 1925 Country, Director Massachusetts Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director MD Montgomery Silver Spring 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 14400 Homecrest Road 20906 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. WWII 1 Yes 2XX No Specify: Completed 3 Nidowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) F.B.T. Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Loretta Pineau ျ Cornelius J. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa C. Jackson /Daughter 13750 Notley Road, Silver Spring, MD 20904 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State May 10, 2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary artery disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ξ Month Day Year Pregnant at time of death 2 No as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed Advanced dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed Diabetes mellitus 2 🗌 No this certificate 1 🗌 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Living Hospital Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဂ္ 4 Nursing Home 5 Residence 6 V Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work' 5 Pending nours after death.

neral Director: Af
iffled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled i Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D063999 May 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

17904 Georgia Avenue, #304, Olney, MD 20832 haved 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State

Registrar

MAY 06 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20<u>10</u> **Physician** 9:40 am Smith L. Yancie May 02 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fort Washington

| Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washington | Fort Washin Fort Washington Medical Center Prince George Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F 55 |578**-**70-6708 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Oxon hill 1 XYes 2 No Md Prince George rai", or items 23a or 28a-f sh Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 USA B08 Brockton Rd Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ne filed within 72 hours after or all Hygiene. I other than "natural", or iter 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ò 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American University Telephone Tech 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental H Robert Smith Geneva Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 308 Brockton Rd Oxon hill Maryland 20745 Nathan Smith (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Department of important: If it any injury or o 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemet May 08,2010 Brentwood, Maryland 4 Donation 5 Other (Specify) of Funeral Parvice Licens 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St.NW WashDC Approximate Interval Between Onset and Death 23a. Part1. Epter the disease, or conshock, or heart failure. List only that caused the dea e on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) rotic oronar oscite Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transi and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Dertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Tyes ٥ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

P.0. Division or Vital Records,

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Sachdeva, MD 29c. License number

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2010

Md.20744 Fort Wash Medical Ctr 11711 Livingston Rd, Ft. Wash

Deepak 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(Check only

32. Registrar's Signature

MD

MAY 10

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5/04/2010 10:19.p MARY ANN STAUNTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2* F Days Hours Min. WEST VIRGINIA Director 233-58-4867 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🙀 Yes 2 🗌 No DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a Funeral 20002 UNITED STATES 149 RHODE ISLAND AVE. NE items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ori 1★ Never Married 2 Married Completed by 1 Yes 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: BLACK "natural", 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 thand Mental Hygiene. 37 is marked other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) HEW 12 SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RUTH BENTLEY MOSES STAUNTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health t 5810 84th AVE, NEW CARROLLTON, MARYLAND 20784 NORMAN STAUNTON Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If its 1★ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 5/10/2010 SUITLAND MARYLAND WASHINGTON NATIONAL 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 21. Signatule of Funeral Service Licensee 300512th ST. NE WASHINGTON DC 20017 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the Approximate shock, or heart failure. List only one caus on ea Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Exami death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE ase yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Day Month Year Pregnant at time of death 9 Unknown hed g Unknown P.O. ed by t detach signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Hospital or Attending Physician; The certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/gr investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of confi 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, 32. Registrar's Signature State Registrar

		-	For State Registrar	State of	of Marylar		artment <i>tificate</i>			and M		giene Reg. No	010	160	60
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath		3. Time of	Death
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	Examin		4a. Facility Name (if not institution,	_			4b. City, T		Location o	of Death			ounty of Death		
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	vith th		10618 BISHOPVI	LLE ROAD				218	13			US		,.	
	eath v tems er mu	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13. \	Vas Decede			gin? (Spec	cify Yes or No- Rican, etc.)		. Race - Americ		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	<u></u>	1 Never Married 2 Marri	ied 1 Tyes If Yes, Giv	2 🔯 No		Yes 2				iicai, cic.j	Spe	Black, White, ecify: WHI'		
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Elizabeth Williams Baltimore, Maryland 21215-0036	permit. Page 1 a Department of F Important: If its any injury or of		21. Signature / Fun ral Service Li	gense	0		. Name and			•				10055	
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/ita	siciar certif	To Be	examiner? 1 \sum Yes 2 \sum No	Hospital:	Inpatient 2	EB/Outpatier	± 3 □ DO	Otho	r:			lence 6 🗆	Other (Specify	1	
of/	g Phy er this neral c		27. Manner of Death	28a. Date		28b. Time of injury		c. Injury work?			8d. Describe h			/	
O	eath. or: Aft	fica	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	ation			М	1 🗆 \	Yes 2□	_					
Division of Vital Records,	or Att	Certificate:	4 Homicide determine	28e. Place	e of Injury - At he ing, etc. (Specif	ome, farm, stre y)	eet, factory,	office		2	28f. Location (S City or Tow		umber or Rurai	Route Numbe	er,
	spital lours a neral (29a. Certifier 1 Certifying	Physician: To the b	pest of my know	/ledge, death o	occured at the	he time,	date and p	olace, and	d due to the car	use(s) and m	nanner as state	d.	
	To the Hospital or Attending Physician: The law requires that the death certificar within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Ex	xaminer: On the bas Nurse Practioner:	sis of examinatio	on and/or invest	tigation, in m	ny opinior	n, death oc	curred at	the time, date a	nd place, an	d due to the ca	use(s) and mar	iner stated.
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	el		30. Name and address of person we Pennie Savac					y Di	c, B	erli	n, MD	218	311		
	Stat Registra	-	31. Date filed (Month Day Year	2010 32.5	gistrar's Signa		had	4							

		1- For State of Maryland / De Registrar	partment of Health a Certificate of Death	nd Mental Hy	/giene	16061
Physic /Med		1. Decedent's Name <i>(First, Middle, Last)</i> James Albert Adams	Sr.	2. Date of D Month MA	Pay Year	3. Time of Death
Exami		4a. Facility Name (If not institution, give street and number) Summit Park Health & Rehab.	4b. City, Town, or Location of Catonsvill		4c. County of Dea Baltimor	е
Funera Director		5. Social Security Number 234 40 6966 6. Sex 1 M 2 □ F 7. Age (In yrs. last birtho	Months Days Hours	4 Hrs. 8. Date of B (Month, D) 04/30	irth $_{ m Pay,\ Year)}^{ m 9.\ Bir}$ $^{ m 9.\ Bir}$ $^{ m Ve}$	thplace (State or Foreign buntry) est Virginia
Maryland 9-1 show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland N/A Balt				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
death with the Maryland ms 23e or 28e-f show Frest to retifice at	Funeral Director	10e. Street and Number 4814 Brairclift Road	10f. Zip Code 21229		10g. Citizen of What Co	ountry?
1036 ours after dea rel', or Items	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Status 1 Never Married 2 Married In Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Status 14. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Status 15. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Status 16. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Status 1 Never Married In Status 1 Never Married In Status 1 Never Married In Status 1 Never Married In Status 1 Never Married In Status 1 Never Married In Status	3. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 X No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	Specify	
21215-C d within 72 h giene. "natu er then "natu Ire Medical	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most e. DO NOT use retired) echanic	of working	Juke Box	Industry and Pinball
yland y ould be file ! Mental Hyy serked othe	To Be C	17. Father's Name (First, Middle, Last) John Adams		s Name (First, Middle Winnie Ho	11oway	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 271s marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, tre Mexical Examination and Incentional Legisland		Kelly Adams / Daughter in law 400 20a. Method of Disposition 1 Region 2 Accompation 3 Regnoval from State 20b. Place of Disposition commetery.	ailing Address (Street and Number 11 - 4th Street sposition (Name of trematory or other place) Crematory (imore, Mary	1and 21225 Town, State
Baltii pernit. 1 Departe Importe any inju		21. Signature of Fulleral Service Licensee	22. Name and Address of Facility 4001 Ritchie Hi	Gonce Fu	neral Servio	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each limb death. Do not Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	enter the mode of dying, such as o		arrest,	Approximate Interval Between Onset and Death
60, · · be executed clain and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
O. Box ne death cert the attendin	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
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ion of Vita nding Physicien: alth. r. After this certific e funeral director.		1 Yes 2 No 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury In	of 28c. Injury at	28d. Describe	how injury occurred	ciry)
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral princip	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Ri own, State)	ural Route Number,
e Hosp 24 hou e Funei letely fil	edicai	29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/o and manner stated.	eath occurred at the time, date and investigation, in my opinion, death	place, and due to the occurred at the time	cause(s) and manner as , date and place, and due	s stated. to the cause(s)
To th within To th	Me	29b. Signature and the or conflier	29c. License number	165	29d. Date signed (Mont	
		30. Name and address of person who completed cause of death (Item 23a) (Ty)	D0061		MAY 15"	
			50 WILLERS	AUE #3	7 BALT. 1	WO 21229
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature AAY 24 2010 Across 5. Across 5.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alice V. Bentley 5:00 P. M May 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3908 - 8th Street N/A Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛱 F 93 Days Months Hours 07715/1916 Virginia Director 217 12 5658 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits N/A Baltimore 1 X Yes 2 No Maryland 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3908 - 8th Street 21225 U.S.A. items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? or. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural" 3 X Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th Nurse Nurses Registry Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Ross Ada Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Metcalf / Niece 813 Pontiac Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Mem. Gardens 05/18/2010 Staunton, Virginia 22. Name and Address of Facility f Fuseral Service Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Dav Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has performed. Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, r of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) ✓ Natural 5 Pendina after death. Director; Af ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Aditya Chopia

24

31. Date filed (Month, Day, Year

Glen Burnie, Maryland 21061

7575 Ritchie Highway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Dav Year Dorothea S. Bassett 9.30 PM 2010 /Medical 4b. City, Town, or Location 5. ...

ALTIMORE 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Aug. 7, 19) 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GNES HOSPITAL Social Security Numbe 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕱 F 090-20-6512 Director 91 New Jersev Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c City Town or Location ?? is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinor must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 715 Maiden Choice Lane CC401 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗵 No Specify \$ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. In a M Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Schroeder Ellen O'Grady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jayne Prin 772 Spring Bloom Drive; Millersville, MD 21108 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 5/25/2010 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. MD 21228 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician METABO FVERE OURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LOURS CHEM! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) o 9 Unknown ģ 0 signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, FAILURE 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 sl autopsy The perform certificate 1 ☐ Yes Division of Vital 1 □ Yes 3 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day, Year) 1 24 hours after death.

In Funeral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 5. CATON AVENUE ALTIMORE AUGUSTO AIB CNITI 31. Date filed (Month 32. Fegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2300 M Medical **Examiner** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎗 F Days Hours Months Min. May 29, **Director** 87 Maryland 1922 213-16-1593 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Hillside Dr. 21776 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph T. Coe Carrie R. Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Carver - daughter 309 Hillside Dr., New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Pipe Creek Cemetery 5/21/2010 nr. Linwood, MD 21. Signatur of Funeral Service Licensee Hartzler Funeral Home New Windsor, 310 Church 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical D e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Yo Pregnant at time of death 5 Other (specify) Month Dav Year n signed by the a 1 ☐ Yes ∠ L 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy perform ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျု 1 🗌 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗆 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a d title of cert 29d. Date signed (Month, Day, Year) MD s of person (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1415 Louise Catherine Brown 05 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1<u>924</u> 1 □ M 2 🕱 F Days 86 Director Feb. Maryland 220-16-2750 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Carroll Union Bridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 924 Winters Church Rd. 21791 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify. White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Bookkeeper Insurance Co. permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumastic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delta E. Dinterman Dave Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl B. Brown - husband 924 Winters Church Rd., Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/19/2010 Meadow Branch Cem. Westminster, MD 21. Signator of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ENTRICULAR disease or condition) Medical resulting in death) Examiner MYOCARDIALINFARCTION ANTERIOR Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dralsdey Tolla Lus 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 욘 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 A Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

29b. Signature and title of certifier

CHITIACUEDY

hachelle N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAGANNA

egistrar's Signatur

700A

29c. License number

DI8 200

poole Rd, WESTMINSTER MD

05-16-10

10-03877

nyllis V. Bradley	State of Maryland / Department			0 1606
	1- For State Certificate	of Death	Reg. No.	0 1000
Physiciar ledical Examine	er Phyllis Vernella Bradley		Date of Death Month Day Year May 21, 2010	3. Time of Death 0113 hrs
	4a. Facility Name (if not institution, give street and number) Northwest Hospital	4b. City, Town, or Location of Death Randallstown	4c. County of Dea Baltimore Co	
Funeral Director	5. Social Security Number 525-80-0933 6. Sex 7. Age (In yrs. last birthday) 71	y) If Under 1 Year If Under 24Hrs Months Days Hours Mir	April 6 1939 Fore	Birthplace (State or eign NM Country)
Aaryland 28a-f show any Latonce.		gs Mills		10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 9122 Groffs Mill Drive	10f. Zip Code 21117	10g. Citizen of What Co USA	ountry?
er death wi	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	o Rican, etc.) White, etc.	erican Indian, Black, ite
5-0036 led within 72 hours a lygiene. other than "natural the Medical Examin	Flementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use ret omemaker	work done liked) 16b. Kind of Busines domestic	s/Industry
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) Jesus Chavis		e (First, Middle, Maiden Surname) Rodriguez	
y, MD 2121 and 2 should be fi teath and Mental tem 27 is marked fraumatic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or 22 Groffs Mill Dr.	Rural Route Number, City or Town, Sta , Owings Mills, Md	ate, Zip Code) l 21117
Baltimore, I permit. Pages I and Department of Healt Important: If item injury or other tra	1 Burial 2 XCremation 3 Removal from State All County of A	,	Date 20c. Location - City of Sykesvill	e, MD
Balti permit. Departu Import injury	Garge Harger Herbert	P.O. Box 195 Syk	ight Funeral Home esville, MD 21784	& Chapel
Physician Lindical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Immediate Cause (Final disease		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): b.			
_ =	if any, leading to immediate cuse. Enter U denty in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
executian and ial - tra	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician properey filled in the funeral director, page 2 should be detached for use as the built of the funeral director, page 2 should be detached for use as the built of the funeral director.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown Part II. Other significant conditions contributing to death but not resulting in	Fetal death 3 Ectopic pregna	ancy 23d. Date of deliver	ery Day Year
, P.O. Barries that the designed by the	à	the underlying cause given in Part I.	23e. Did tobacco use contribute t	to the cause of death?
of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should b			autopsy prior to performed? death?	autopsy findings available o completion of cause of Yes 2 No
cian: The certificate rector, page	25. Was case referred to medical examiner?	26.Place of Death (Check		
of Vi Physical directhis	27 Manner of Death 28a Date of Injury 28b Time	TOTAL OF BOX	ng Home 5 Residence 6 Oth 28d. Describe how injury occurred	ner:
on of anding Plats. T: After he funera	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	, ,	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the h	Natural 5 Pending Accident Investigation Suicide 6 Could not be determined (Specify) (Month, Day, Year) (Month, Day, Year) 28e. Place of Injury - At home, farm, (Specify)	street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
To the Hosp within 24 ho To the Fune completely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investance and manner stated 29b. Signature and the of certifier			
	Just fatter feel	29c. License number O.C.M.E.	29d. Date signed <i>(N</i> May 21, 2010	fonth, Day, Year)
21	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	1 Penn Street, Baltimore, MD	21201	
Star	20 Posistado Signaturo			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kae 2237 umber 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospitz Randallstown Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F 0370171916 94 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland notified at Director 28a-f 1 Tes 2 No OWINGS MILLS MD BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 3420 ASSOCIATED WAY, #219 21117 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. WHITE 3 ☐ Widowed 4 ☐ Divorced Completed it of Health and Mental Hygiene.
If item 27 is marked other than "nature or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SAMUEL LEAVEY REBECCA LAZIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau MILES BLUMBERG/SON 2403 CRESTNOLL ROAD, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Diaposition (have of DATH centre). From Both of the Alace H 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE, MD ISRAEL CEMETERY 5/21/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Ser 22. Name and Address of Facility ^{2. Name and Address of Facility} SOL LEVINSON & BROS., 1 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 53166 disease or condition resulting in death) 0 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metabolic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1- Natural 5 \square Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 32811 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suste 108 Randally town 24133 1409 5400 Old

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ William 03:15 AM (unrad 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HUPKINS BAYUTEN MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08/25/1937 Mary land Director 214 38 6565 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 þé ms 23a o Funeral 3815 - 3rd Street 21225 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner n 14. Race - American Indian, rmed Forces? Black, White, etc. Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White of Health and Mental Hygiene.

item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Salesman Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Conrad Page 1 and 2 should be т ment of Health and Menta Mary Evelyn Oakjones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Sandra Conrad / Wife 3815 - 3rd Street 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, # 5 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Department o Important: If any injury or once, 05/21/2010 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Gonce Funeral Service, P.A. hway Baltimore, Maryland 21225 4001 Ritchie Highway rancous complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease... Approximate Interval Between Onset and Death shock, or heart failure List Immediate Cause (Final Physician/ ANEURYSM INFECTED AORTIC disease or condition resulting in death) THORACIC MUNTHS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day sate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 18,2010 1401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE, BALTIMURE, MD 21224

DHMH 17 Rev 7/2009

State Registrar ARMAN

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

4940

M.D.

32. Registrar's Signature

KILIC

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Elizabeth Street Collins 2010 1:54 A. May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 213 28 7491 Maryland 78 Director Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notifled at 10d. Inside City Limits Director Baltimore 1 Yes 2 No Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2300 Dulaney Valley Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 🛮 Widowed 4 🗆 Divorced White Year or Dates. traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Caretaker Sisters of Mercy Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nicholas Myer Julia Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 658 North Branch Court Brian Collins / Abington, Maryland 21009 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 05/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final Onset and Death Physician/ LYMPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of framy leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 **X** No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending work 1 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tip

Registrar
DHMH 17 Rev 7/2009

State

2010

COLLINS

ELIZABETH

2300 DULANEY VALLEY RD.

TIMONIUM,

MD 21093

erson who completed cause of death (Item 23a) (Type, Print)

JONES,

31. Date filed (Month, Day

CRNP

2010

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month Day May 16, 2010 Mary Patricia Costello Medical Examiner 2110 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Director 212-64-5604 55 1 M 2 X F July 13, 1954 Yrs Missouri Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19645 Crystal Rock Drive, Apt. 13 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 X No Yes White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet 12 Food Service Grocery Store 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Joseph Costello Evelyn Loretto Bader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Schroth/Daughter 13401 Fountain Club Drive #203, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date May 28, 2010 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Millais M01173 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and (Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transi sician/Medical UNPENDED AMENDED certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy 2 Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Phy Records, P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ই 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, this certificate has been a il director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other Mursing Home 5 Residence 6 Other: ဥ 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred May 16, 2010 Pedestrian struck by auto To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A Natural 2032 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 118 at Crystal Rock Road, Germantown, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and litle of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2010 el 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Regist ar's Signature 31. Date filed (Month, Day, Year, State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Physician/ Month 2010 5:15P M Phyllis R. Cowan May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8108 Analee Avenue Baltimore Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) 74 yrs. 6. Sex Birthplace (State or Foreign Country) MD **Funeral** 1 🗆 M 2 🔀 F Yrs 213-32-1774 **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore Rosedale 1 🛚 Yes 2 🗆 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be Funeral 23a 8108 Analee Avenue 21237 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Tulkoff Foods Data Entry Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Unknown Simons Lucille Brockman permit. Page 1 and 2 should be Department of Health and Ment Important: If Item 27 is marke any linjury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Cowan-Husband 8108 Analee Ave., Rosedale, MD 21237 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Bayview Crematory | 5-21-10 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of FacilityBradley-Ashton Funeral Home, Signature of Funeral Service 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ alvular Heart 2 No 3 Probably 4 Unknown Completed Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 - N 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner eath funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 Tes 2 🗌 No Investigation Could not be the f 2 Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0057021

State Registrar 32. Fegistrar's Signature

Philadelphia Rd Ste 106 Baltimore

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mathur, M.D. 9106

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAYnth 18 **COOPERMAN** 20°10 1:17 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 3408 OLD FOREST ROAD BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1 XM 2 | F Months Hours 10708/1926 079-20-9745 83 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 Tes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3408 OLD FOREST ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Amoned Forces?

1 Yes 2 No Black, White, etc.
WHITE þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Completed Specify. 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) WINDOWS AND DOORS OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ COOPERMAN YETTA NAGEL ISIDORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERTA COOPERMAN/WIFE 3408 OLD FOREST ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of ceAR4) I 464 ON TO STATE OF THE CONTROL OF THE Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) AMUNO CEMETERY 5/21/2010 BALTIMORE, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the destable shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 2 🗌 No 2 No 1 🗌 Yes ☐ Yes sompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) Mo ess of person who completed cause f death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May ^{Day} 2010 Ferne S. Erskine 20 21:08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 8, 1920 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Pennsylvania Hours Director 176-14-1685 89 Aug. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19167 Stedwick Drive 20886 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ρ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes. Give White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar J. Striffler Katherine Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a John M. Erskine/Son 2702 Lindell Street, Wheaton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 10, permit. Page 1 Department of Important: If it any injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 2010 Arlington, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy
7557 Wisconsin Avenue, Bethesda, Maryland 20814 Chase, Inc Willian M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiomyopathy Medical resulting in death) Due to (or as a consequence of Examiner Aortic Stenosis Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Litter officerying Cause (Disease or iinjury that initiated events Exami resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE: nse 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Month Pregnant at time of death the 9 Unknown P.O. Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Atrial Fibrillation, Pulmonary Hypertension, 2 🕅 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of Cellulitis, Peripheral Arterial Disease 24a. Was an has autopsy performed? Yes 2 N death? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 X Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ane

Santosh Rane, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Rane'. MD

32. Regist ar's Signature

29c. License number

9901 Medical Center Drive, Rockville, Maryland

D068178

29d. Date signed (Month, Day, Year)

May 215+, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month 05 17:11PM Faison 21 Marie 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 M 2 X Months Days 70 1-14-1940 MD 220-36-6050 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Oa. State 10b. County 1 X Yes 2 □ No **EDGEMERE** BALTIMORE MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21219 2710 LODGE FARM RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Yes 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) NURSING HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEATRICE DAMERON DOUGLAS SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2710 LODGE FARM RD. BALTIMORE, MD GEORGE FAISON/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 5-27-2010 CEDAR HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myoc ardial infarction acute disease or condition resulting in death) Due to (or as a construence of): Coronary artery Sequentially list conditions

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show notified at

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'natural",

ental Hygiene. ced other than "natura c event, the Medical E

Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director; A
completely filled in by the

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Hospital

Examiner Physician/Medical <u>ک</u> Completed Be ပု Certification: Medical

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 S No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check onlone
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Manpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence 6 Other (Specify)
27. Manner of Death 1 ↑ Natural 5 □ Pending 2 □ Accident investigation		8d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	rsician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29c. License number

RES-000

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

HSU Steven 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

May

29d, Date signed (Month, Day, Year)

21, 2010

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:30p Physician/ Raymond O. Fleming Jr. May Day 2010^{ear} 22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospital Center Carrol1 Westminster 5. Social Security Number 8. Date of Birth April ^{(Month}Day, ^{Year)}1941 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Country) MD Days 1 1 M 2 □ F 212-38-0929 69 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1570 Deer Park Road 21048 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? 1958—1 No 1961
If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Raymond O. Fleming Rose Swiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Willow Avenue Westminster, MD 21157 Tammy Fleming/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Providence Cemetery 1 XBurial 2 Cremation 3 Removal from State 5-26-10 Gamber, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ CANCEL disease or condition resulting in death) ANCREATIL Medical Examiner 2 weeks ERFORATED Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last physician are the burial-t Physician/Medical as I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 2 🗆 No 1 TYPS Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Hospital or within 24 hours after death.
To the Funeral Director. After thi 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D00 62065 5/22/2010 SARICAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Avenue, Westminster, MD 21157 <u>Saiyad Sarkar.</u> M.D. 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 7/2009 MAY 24 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Physician/ MAYnth 20°10 8:00 FRAME Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 6104 IVYDENE TERRACE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Hours Min 0470371946 64 Director 212-50-1656 MD Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o edical Examiner must be Funeral 6104 IVYDENE TERRACE 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha NON-PROFIT EMPLOYEE MEDICAL RESEARCH Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ROSENBUSH, JR. LOUIS ALICE SINSHEIMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 LINDEN AVENUE, APT. 1, SOMERVILLE, MA MICHAEL FRAME/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) BALTIMORE HEBREW CEM: 5/21/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD of Funteral Service Linens INC. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician BRAST CONCEN M GTASTAT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examine if any, leading to immediate cause. Enter tridenting Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy Yes 2 X No 1 Yes 2 No Be the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation after death Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [2] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12.25AM **Physician** JOHN 23 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SEASONS HOSPICE AT NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 X M 2 □ F 223-26-0019 VA MAY 19, 1925 Director 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Experimer must be notified at 10a State 1 X Yes 2 □ No Director GWYNN OAK BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6715 CAMPFIELD ROAD 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 2 **X**No 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: δ 3 Widowed 4 Divorced BLACK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EASTERN STAINLESS STEEL TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be VIOLA HARRISON ပ JAMES EDDIE GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 BALTIMORE, MD 21207 6715 CAMPFIELD RD. JOHN EDDIE GREEN, JR. / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State LAWRENCEVILLE, VIRGINIA GREENTOWN FAMILY CEM. 5-29-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ure of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List only one cause on eacl line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner burial-tran resulting in death) Last Due to (or as a consequence of) tending physician a r use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ed by the g 1 Tyes 2 No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown FUITU 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? ISBASB 24a. Was an certificate has autopsy performed' page 1 ☐ Yes 2 2 No 1 □ Yes 2, director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A death. 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI) Melle 30 Name and address of person who completed cause of death (Item 23a) Type, Print) SMITE 283 nu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** <u>07:4</u>3^{ам} **JAMES** MAY 0 2010 WILLIAM GREGG /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BELAIR
If Under 1 Year | If Under HARFORD CO 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Director 220-34-5967 DEC. 13 1938 MARYLAND Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location 28a-f show d other than "natural", or items 23a or 28a-f slevent, the Madical Examiner number confilled Director 1 ☐ Yes XX No <u>JO</u>PPA MARYLAND HARFORD CO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 SINGER RD. 21085 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Deceden. _ Armed Forces? 1 □Yes 2 📉 📢 o 1 Yes 2 1 XX ever Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 9th grade GROMMER RACE TRACK Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental JOHN W. GREGG ပ္ ANNIE F. GREGG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Woods/Sister 2101 Singer Rd., Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Kremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 05-24-10 BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. S PHILA. BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): neek disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner Due to (or sels conesquence of) cause. Enter Underlying Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 Tyes 2 THO 9 Unknown cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □ Yes 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA cal Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vesreen Kurtom

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:45 P. M Amelia Marie Horner Mav 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City, Town, or Location of Death Caroline Home For Hospice Caroline Denton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 1 □ M 2 🗗 F Months Days Hours Min Country) Maryland 90 220 03 0280 09/17/1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Caroline 1 ☐ Yes 2 👿 No Maryland Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15181 Oakland Road 21636 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📆 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Doctor's Office 12th Office Assistant Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Matthew Schiffler Mary Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Calvert / Daughter 5404 Park Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/27/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. tecome manujor 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final (on3 disease or condition resulting in death) Due to (or as a consequence of): 91010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Hospice1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 1 🔁 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

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Health 27

Department of Health Important; If Item 27 any Injury or other to once.

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P.O. Division of Vital Records, or Attending Physician: Jospital C.
4 hours after dea...
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Jorge Abrego, MD 31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Suite 104 Easton, Maryland 21601

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

598 Cynwood Drive

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charlene, Hopkins Month Year 2048 M 2010 05 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death N/A **Examiner** 4b. City, Town, or Location of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 63 Month, Day, Y 218-44-4053 **Director** MĎ Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore MD N/A 1 X Yes 2 No I0e. Street and Number 10f. Zip Code 21217 10g. Citizen of What Country? 827 Arlington Ave Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🖾 No 1 Never Married 2 Married African Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Amer. 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Dana's Tire Elementary/Seconday (0-12) College (1-4 or 5+) Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ralph Crowner Christine Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Crosby/Daughter 1805 Ashburton St.,Balt.,MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
. Zion Cem. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 5/27/10 Balt.,MD Mt. 4 Donation 5 Other (Specify Signature of Funeral Service Licens ^{22. Name and Address of Facility}Hari P. Close F.Svs.PA 5126 Belair Rd,Balt.,MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final septicemia Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 3 months leukemia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of iii ijury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Contifying Number Frontian Control of my knowledge death occurred at the firm, date and place and due to the cause(s) and manner as stated. (Check 29c. License number 1679774298 May, 22nd, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore, MD 21201 Z Morton 32. Regirar's Signature State Breun Registrar

DHMH 17 Rev 7/2009

		•	For State Registrar	Amend I	tems 8,23a,	areianan ya C	p agnosi/ ertificate of l	1472010 Death	ing ental Hy	giene Reg. No.	10 16081	
П	Physicia	ın/	1. Decedent's Name						2. Date of De	eath Day	3. Time of Death	
_	Medic	cal	4a Facility Name (if		ustin Chapn ive street and number)	nan Hilleg		al anation of Do	May	2 2	010 7:40 P M	
	Examin	ier	Sinai		al of Balti	more	4b. City, Town, o		atn	4c. County	Baltimore City	
	Funeral		5. Social Security Nu	mber 6	. Sex 7. Ag	e (In yrs. last birthda	/) If Under 1 Year		rs. 8. Date of Bi	nt10/24/19/6	9. Birthplace (State or Foreign Country)	
	Director		215-04-7 Usual Residence of I		19 11 2 2 1	33 Yrs				Oct 21, 1978 MD		
	land show d at	tor	10a. State	10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	Mary 28a-1 notifie	irec	MD		Howard			Ellicott	City		1 ☐ Yes 2 No	
	/ith the 23a or st be r	Funeral Director	10e. Street and Num				10f. Zip Code	04040		10g. Citizen of W		
	eath w	Fune	8363 Acade	emy Ka.	12. Was Decedent E	Ever in U.S. 1	3. Was Decedent of H	21043 Iispanic Origin?	(Specify Yes or No	14. Race	U.S.A. - American Indian,	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Marrie	. ,	Armed Forces? 1 Yes 2. If Yes, Give Year or Dates.	No	If Yes, specify Cuba 1 ☐ Yes 2 🗷 No		erto Hican, etc.)	Black Specify:	k, White, etc.	
9-6	hours natura Jical E	ete		15. Decedent's	s Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Bu	siness Industry	
2	within 72 giene. er than " the Mec	Completed	Elementary/Seco		grade completed) College (1-4 or 5	life	ve kind of work done DO NOT use retired)	during most of w	vorking			
42	ed wit Hygien other	Be C	17. Father's Name (F.		:t)		Operati	ons Manag		, Maiden Surname	etail Jewelry	
<u>lan</u>	should be filed and Mental Hy, is marked oth raumatic event.	မြ			, homas Howard	Hillegass		TO. WOULER ST		inda Lee Ha		
lary	should and M is ma aumal		19a. Informant's Nar			er, City or Town, St						
<u>√</u>	and 2 s Health tem 27		Kristin Hill 20a. Method of Dispo		spouse		63 Academy I	Rd. Ellicot				
Baltimore, Maryland 21215-0036	Page 1 anent of 1 ant: If its		1 Burial 2	Cremation 3	Removal from State		position (Name of rematory or other place	i	Date		City or Town, State	
ij	permit. Page Department Important: II any injury or once.		4 ☐ Donation 21. Sign ture of Fun	ral erv Lic	_	Good S	Shepherd Ceme 22. Name and Addre		lay 06, 2010	Ellico	ett City, Maryland	
m	Depar Impo any ir		► Vwad	Make	to Que M	101793			e, P.A. Pike Ellicott	City, MD 2104	3	
	Physician/ Medical Examiner	ıer	shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List onl	Metasta b.	e. renal fai a consequence of):	nter the mode of dyin		ac or respiratory a	rrest,	Approximate Interval Between Onset and Death I 3 clays	
1760	cate be e physiciar the burit	edical Examiner	cause. Enter Underl Cause (Disease or ii that initiated events resulting in death) Li	njury	с	Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	B	су		23d. Date Mon	e of delivery tth Day Year	
s, P.C	ires that signed b	d by P	Part II. Other signific	cant conditions	contributing to death b	ut not resulting in th	e underlying cause gi	ven in Part I.			bute to the cause of death? 3 Probably 4 Unknown	
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<u>a</u>	cian: T	Be	25. Was case referred examiner?	d to medical	Illians Mall			ace of Death (Ci		ZECNO	100 2 10 110	
Ž	Physical this of rall directions of the control of	. To	1 Yes 2 2	No	Hospital: 1 🗵 Inpatie 28a. Date of injur	ent 2 ER/Outpat		4 L Nursing		dence 6 Other		
o uc	nding ath. : After e fune	icate	1 🛭 Natural 2 🗌 Accident	5 Pending	(Month, Day	(, Year) injury	work		28d. Describe	how injury occurred	a e	
ivisio	or Atter after des Director in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	t be 28e Place of Injur	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (City or Tox		r or Rural Route Number,	
0	ne Hospital or Attending Physin 24 hours after death. Funeral Director: After this pleted filled in by the funeral di	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of ex	xamination and/or inv	estigation, in my opinio	on, death occurre	d at the time, date	and place, and due	to the cause(s) and manner stated	
	To the within To the comple	Σ	only one) 3 to 29b. Signature and ti		urse Practioner: To the	pear of thy knowledg	29c. License		place, and due to th		(Month, Day, Year)	
) cur	MD.			RES	S-000		May, 2,	2010	
\					o completed cause of de			401 W B	elvedore 1	ore Balh	more MD, 21715	
	Stat		31. Date filed (Month,	Day, Year)	32. Registra	ar's Signature				-		
	Registra	ir	# A Y	24 20	U Kenn	p. 190	A COUNTY					

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		•	1 - State Registrar				rtificate of				Reg. N	711	10	160	382
	Physicia	ın/	1. Decedent's Name (First, Midd	le, Last)						2. Date of D		av V	əar	3. Time of De	eath
	Medi	cal	Carrie Mar			gh				May	13		10	4:30	P M
	Examir	ier	4a. Facility Name (if not institution Vindobona Nurs		nber)		4b. City, Town,	or Location		ihts	4	c. County of Fred e		k	
	Funeral Director		5. Social Security Number 212–50–7961	6. Sex 1 \(\text{M} \) 2 \(\text{X} \) F	7. Age (In yrs. 102	last birthday) Yrs.	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Bi (Month, D May 1	rth ay, Year)			ace (State or F y) PA vland	oreign
	id it	<u>.</u>	Usual Residence of Decedent 10a. State 10b. Count	,	100 0	ty, Town or Lo	ocation							d. Inside City I	
	e Marylan r 28a-f sh notified a	Director		ederick		•	Braddock 10f. Zip Code	Heigh	nts		<u> </u>			1 XYes 2	
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36	is filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Dece Armed Fo 1 Yes	2 💢 No		Was Decedent of I	Hispanic Or ean, Mexica		ecify Yes or No Rican, etc.)	-	14. Race - Black,	America White, e	tc.	
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21215-0036	ed within 72 he Hygiene. other than "na ent, the Medic	Completed		est grade completed; College (1		(Give	dent's Usual Occu kind of work done O NOT use retired	during mos ()	st of worki	ing	T	Kind of Busir Own ho		ustry	
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Mar	2 should th and Me 27 is mar traumati		19a. Informant's Name/Relations		_	1	ng Address (Street				-				
	and Heal		Darlene Haines 20a. Method of Disposition	/ caugnter	20b.	Place of Dispo	eorgetown	- 1		alkers		ocation - Cit			
mo	Page 1 nent of I ant. If its		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other		Jiaic		matory or other pla		5/17	/2010	1	odsbo	-		
Baltimore,	permit, Page Department o Important: If any injury or once.		21. Signature of Funeral Service	License, XX	able	/ 2	2. Name and Addre	ess of Facili	^{ity} Har	tzler 1	Fune:		me		
	Prrysiciam / Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	caused the dea ich line. (or as a conseq	dem	er the mode of dyi	ng, such as	cardiac c					Approximate Interval Betwee Onset and Dea	ath
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. Box 68760	he death certificate be execut y the attending physician and ched for use as the burial-tra		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 J No 9 ☐ Unknown	23c. If yes, out 1 Live 4 Preg 9 Unkr	Birth 2 D Fet nant at time of	aldeath 3	☐ Ectopic pregnar ☐ Other (specify) _	ісу				23d. Date o Month		y Day Yea	r
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed by	Confestre	heare.	failu	e	0 0				psy ormed	, prio dea	r to com th?	sy findings avai	ilable se of
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ion of	To the Hospital or Attending Physician: "In the Funeral Birector: After this certification for the Funeral Birector: After this certification for the Funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director director, the funeral director dir	Certificate:	27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	igation	th, Day, Year)	28b. Time of injury	M 1	ryat k?]Yes 2 □		28d. Describe	how inju	ry occurred			
Divis	oital or At urs after o ral Direct		4 Homicide determ	nined 28e. Place buildii	ng, etc. (Specif	y) 	eet, factory, office		- 1	28f. Location (City or To	wn, State	9)			
	the Hosp nin 24 ho the Fune npleted fi	Medical	(Check 2 ☐ Medical only one) 3 ☐ Certifyin	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of examinatio	n and/or inves	tigation, in my opini	ion, death o	ccurred at	the time, date.	and place	e, and due to	the caus	e(s) and manne	er stated.
	70 Witi		29b. Signature and title of certific	W Ben	1 hs)	29c. Licens	se number 3207	3		29d. Da	ate signed (M	onth, D	ay, Year)	
			30. Name and address of person Kathken W), Stern	WS	16/1	A /	4 au	re,	Bru	nsu	rck,	M	d, 21	716
7	Stat Registra		31. Date filed (Month, Day, Year)	Y 24 2010	egistrars Signa	iture A.	parke	1	,			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Day Ingebrigtsen MAY 8:250 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Aud 4, 90 Maryrand **Director** 212-12-0928 ^{ea} 1919 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Mary land Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be 23a Funeral 28 Alleghany Avenue 21204 U.S.A. items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Clerk (Give kind of work done during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ည Percy Thomas Pumphrey Schmidt Augusta permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Pumphrey/ Sister 28 Alleghany Avenue Towson, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Cathedra I Cemetery May 22, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fut. al Sec Ce Lin 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOGENIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MYOCARDIAL HOURE ACHTE INFARCTION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 🗌 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Mapmer of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide (Month, Day, Year) injury 5 Pending after death Investigation 1 ☐ Yes 2 ☐ No completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certif 29b. Signature 29c. License number MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 31. Date filed (Month, Play Year) Registrar's Signata State Registrar

10-03752 Brenda James Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		For State egistrar			Certific	cate of De	eath		Reg	3. No.	
Physician/	1	Decedent's Name (First, M	iddle,Last)					Date of Death Month	Day Year	3. Time of Death
Medical Examine	er	BRENd	Q.	C,	SAW	res			May 15, 20		2305 hrs
	4	a. Facility Name (if not institute 1414 West Mosher	_	e street and number)			ity, Town, or Lo	cation of Death		4c. County of Dea	ath
Funeral	5.	Social Security Number	6. Se	x 7. Age (In yrs. last bi	-		If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. E	
Director	2	214-40-217 sual Residence of Deceder		M 2 F	6	8 Yrs.	onths Days	Hours Min.	6/./.	1941	ountry land
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nore, MD 21215-0036 sees I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23s or 28s-f show any other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		De. Street and Number	sher	e Hree	f	10f	. Zip Code 2/21 °	7	106	g. Citizen of What Co	ountry?
r death with or items 23 must be no	1	I. Marital Status Never Married 2	Married	12. Was Decedent Ev Armed Forces?			cedent of Hispar pecify Cuban, M		ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
fler de		Widowed 4	Divorced	If Yes, Give Year) No	1 Yes	2 No s	specify:		Specify:	Lack
ours aft		15. Decedent's Education (Specify on	or Dates: ly highest grade compli	eted) 16a.		sual Occupation			16b. Kind of Busines	s/Industry
22 he rate		Elementary/Secondary (0-	12)	College (1-4 or 5+)		-	f working life. Do			0.	R
5-0036 ed within 72 hour sygene. other than "natu the Medical Exan Completed				3		SIL	Scre	ener		(Slass	Co
Hygorthe Co		7. Father's Name (First, Mid	dle, Last)	. /			18.	Mother's Name	(First, Middle, Ma		
21215-0036 ald be filed within 72 hours afte Mental Hygiene. marked other than "natural", cevent, the Medical Examiner To Be Completed by		Howard - a. Informant's Name/Relati	Pac	(ne Print)	. 10	h Mailing Add	ress (Street or	5510	TRICE	er, City or Town, Sta	to Zin Codo)
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mest To Be Com			\ /	(pe, Print) S,——— and	1	3017	MaTTh	ing (V)	Heoot	De Hino	ce UL.
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드 스 의 트 노	2	Donation 5 Other I. Signature of Funer 1 Sen	Specify:	See .	May.	, ,	CEMATOR: and Address of	Facility M	Hor ma	Jeonal Han	- (That est
Balti permit. Departir Imports		Valle.	n	00.	1	16.2	0 11	Book	Our li	Balla Mil	2000
Physician	23	g. Part I. Enjer the disease			death. Do n	ot enter the mo	ode of dying, suc	ch as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
/Medical	1	failure. Kist only one car nmediat Cause (First dise		ch line. Hypertens:	ive ca	rdiovas	cular d	lisease			Between Onset and Death
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ag [(E	Disease or injury that initiate vents resulting in death) La		Due to (or as a consequ	ence of):						+
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760, ficate be executed g physician and the burial - transit	IF 23	FEMALE: b. Was decedent pregnant i	n the	23c. If yes, outcome	of pregnancy	,				23d. Date of delive	
68 certifi nding ise as		past 12 months?	i tile	1 Live birth 4 Pregnant at time	e of death	2 Fetal de		Ectopic pregnar	ncy	Month	Day Year
). Box 68 the death certify the death certify the attending to the defor use as Physician	1	Yes 2 ✓ No 9	Unknown	9 Unknown		5 Other (Specify)				
i, P.O. Box 68 irrs that the death certification is signed by the attending be deached for use as do by Physician		art II. Other significant cor	ditions	contributing to death be	ut not resultir	ng in the underl	ying cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
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Records, The law requirer ficate has been sig									24a. Was an		autopsy findings available completion of cause of
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/ital	5	examiner? 1 ✓ Yes 2 No		ospital: 1 Inpatient	2 ER/C	Outpatient 3		205.	-	esidence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after cleath. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach Certification: To Be Completed by P		. Manner of Death		28a. Date of Injury		Time of Injury	28c. Injury a	t Work?		w injury occurred	
endir.	[]		ending	(Month, Day, Year)			1 Yes	2 No			
Visi or Att fter de Direct in by	3		vestigatio ould not b	28e Place of Injury	- At home, f	arm, street, fac	tory, office build	ding, etc.			tural Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	4	Homicide d	etermined						or Town, Sta	tej	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical E.			xaminer:	on: To the best of my king on the basis of examination							
To Sign	29	b. Signature and title of cer		and manner stated.			29c. License nu	umber	1:	29d. Date signed (M	onth, Day, Year)
		Mang - 1	Mel	Kill			O.C.M.E	E.		May 16, 2010	
	30	. Name and address of pers	on who co	ompleted cause of deat	h (Item 23a)						
		Margarita Korell MD	. Ass	sistant Medical Ex			Street, Balti	more, MD 2	1201		
State Registrar	v	. Date filed (Month, Day Ye	242	010 32. Registrar's	Signature	1. Spar	RI				

or Print in Black Indelible Ink. Ensure All Copies Are Legible

ty Louise Jen			of Maryland	/ Depa	rtmen	t of He	alth and	Menta	l Hyg	giene	gibi	20	0	16085
	F	- For State Registrar		Cer	tificate	of De	ลเก 		12	. Date of Dea	Reg. No		1:	3. Time of Death
Physicia edical Examir		1. Decedent's Name (First, Middle,La Betty Lou	ıise Jenk	ring						Month May 15, 2	Day	Year		1034 hrs
		4a. Facility Name (if not institution, gi	ive street and number)	71112			, Town, or Lo	ocation of D	Death			c. County of	Death	
		Rt. 15NB/Roddy Creek R					ırmont	If Under 2	Allen	9. Date of Pi	- 1	Frederick	9 Rinth	place (State or
Funeral Director		5. Social Security Number 6. S 217-28-7117		e (In yrs. la		Mo	nder 1 Year nths Days	Hours	Min.				Foreign Cour	atm.
Director	-	217 28 7177 1	M 2 X F		78	Yrs.		<u> </u>		July	12,	1931		MD_
any	ŀ	10a. State 10b. County		10c. City,	Town or L	ocation.						<u> </u>		10d. Inside City Limits
and show nce,	5	PA Adams		(Getty	sburg		_						1 Yes 2 No
Maryl r 28a-f	Director	10e. Street and Number				10f.	Zip Code				10g. Ci	tizen of Wha		ry?
ith the 23a on notify		429 Barlow Two	Taverns F		S 113	Was Dec	17325		? (Spec	cify Yes or N	0-	U.S.I 14. Race -		an Indian, Black,
eath w items	uneral	1 Never Married 2 Marrie	Armed Forces?			If Yes, sp	ecify Cuban,	Mexican, P	uerto R	ican, etc.)		White,	etc.	
after d	by F.	3 Widowed 4 Divorce	or Dates:	A 110			2 X No				Trans	Specify:		
hours natur Exam	ed t	15. Decedent's Education (Specify	only highest grade con College (1-4 or		16a. Dec duri	edent's Usi ng most of	ual Occupation working life. I	on (Give kin DO NOT us	nd of wo se retire	rk done d)	166.	Kind of Busi	ness/in	austry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	College (1-4 or	51)	Se	creta	rv				P	ublic	sch	nools
5-00 ed with lygien other	히	17. Father's Name (First, Middle, Las	st)					B.Mother's I	Name (I	First, Middle,	Maide	n Surname)		-
121(be fill ental F arked vent, i	å	George E. Morelo			1405.14	-10 a alak		Mar	gar	et E.	Fri	zzell	State	Zin Code)
D 2. should and Mu 7 is m	리	19a. Informant's Name/Relationship Daniel H. Jenkir		n-d		-								PA 17325
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition		20b. I	Place of D		Name of cem			Date	20c	Location - 0	City or T	own, State
MOF Pages 1 ent of 1 other		1 X Burial 2 Cremation 3 4 Donation 5 Other Specia		ale			Cemete:	ry 5	/20/	/2010	1	New Wi	nds	or, MD
altir mit. F partme porta		21. Signature of Funeral Service Lice				22. Name a	and Address	A 57 1919		tzler	Fun	eral H	- Iome	
100	_	23a. Part I. Enter the disease, or con	omu	the death	Do not er	310_C	hurch	St.	New	Winds	or.	MD	217	
Physician		failure. List only one cause on	each line.		. Do not of	ntor the me	so or aying, o				,	,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a cons		f):									
		Sequentially list conditions,	b Due to (or as a cons	edilence o	·t/·					_	_	_	-	
	nine	if any, leading to immediate cause. Enter Underlying Cause	С.				_							
ed nsit	Examiner	events resulting in death) Last	Due to (or as a cons	equence a	of):									
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'60, ate be ohysici ne buri	Med	IF FEMALE:	23c. If yes, outco			J/ 1 <u>4/</u> .	_				2	3d. Date of o		V
: 68760, certificate be anding physical	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	t time of de	2 ath 5	Fetal de		Ectopic p	oregnan	су		Month	Di	ay Year
or atte	Physician/Med	1 Yes 2 No 9 Unkno	wn 9 Unknown		~ L_						1			
s, P.O. Boires that the de signed by the de detached f	by Pr	Part II. Other significant condition	s contributing to deal	th but not r	esulting in	the underl	ying cause gi	ven in Part	I.				_	he cause of death? ably 4 Unknown
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of Vital Records, bg Physician: The law requir where the certificate has been some all director, page 2 should the could be seen as the country of the count	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2] ER/Outp	atient 3				Home 5	Resid	dence 6	Other:	Scene
of \ og Phy ther th	n: To	27. Manner of Death	28a. Date of Inj (Month, Day) May 15, 201	ury Year)	1	ne of Injury		y at Work?	Ir	28d. Describe Oriver auto			ed	
ion ttendii death. ttor: /	atio	1 Natural 5 Pending 2 ✓ Accident Investig	ation		1026 h			es 2 🗸 N	40				s os Dur	rol Pouto Number City
Division pital or Attendi ours after death.	Certification:	3 Suicide 6 Could n					tory, office bu	uliaing, etc.	- 1	or Town, Rt. 15NB/Rd	State)			nont, MD
ing non tel		4 Homicide 29a. Certifier 1 Certifying Physician Control Check only	sician: To the best of n	ny knowlec	ige, death	occurred a	t the time, da	te and place	e, and o	due to the car	use(s)	and manner	as state	ed.
To the Howithin 24 h	edical	one) 2 Medical Examin	ner:On the basis of exa	amination a	and/or inve	estigation, i	n my opinion,	death occu	urred at	the time, dat	e and p	place, and du	ue to the	e cause(s)
E 3 E 3	Me	29b. Signature and title of certifier	í kí				29c. License							nth, Day, Year)
		Mayene Ine	Voille		- 02 - 1		O.C.N	VI. C.			IVI	ay 16, 20	-	
		30. Name and address of person who Margarita Korell MD.	no completed cause of Assistant Medica			11 Penn	Street, Ba	altimore,	MD 2	1201				
s	tate	The state of the s	32. Regišk				-03		-					
Regis		00.000	2010 2		1	60.0	P							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 212 West Hilltop Road Anne Arundel Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Min 237 03 3483 91 Hours North Carolina Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Anne Arundel Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 212 West Hilltop Road 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 🛱 Widowed 4 🗌 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Plus College (1-4 or 5+) Community Nurse Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Lowry Rosa Minggia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Kursch / Daughter 212 West Hilltop Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 05/22/2010 | Baltimore, Maryland 4 Donation 5 K Other (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 2 Part 1. Enter the disease o shock, or heart failur . L. o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last sician a burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably Unknown Completed Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation after death 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie icense number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13 Day Physician/ May Month 20 ľor Joan Porter Leppo 8:29 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 8. Date of Birth NOV 22, 1963 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X Maryland 46 Director 214-90-6755 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Carroll Union Bridge 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21791 7 N. Farquahar St. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk/records keeper County government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Clarence A. Leppo Jr. Ellen Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 107 N. Main St. <u>Clarence Leppo/ father</u> Union Bridge, MD 21791 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o ō 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mountain View Cem. 5/17/2010 Union Bridge, MD 21. Sign tur of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home atharine Union Bridge, MD Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Frection MYDCAROIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 10 rus M uper tensions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ morsing OBESTY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ASTROMS 24a Was an has autopsy performed? Yes 2 No Director: After this certificate d in by the funeral director, pag 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 — Gertifying Nurse Practioner: To the best of high method and death oncurs of the time date and place, and due to the cause(a) and manner as stated 29b. Signature and title of certifier 29c, License number P43643 WD 5.14.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 94. てしみのみ TANENTOUN , MD FISEDGS'CH A-TATE MID. 31. Date filed (Month; Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Billy 2010 May 1:04 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 24, Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) 1. <u>1948</u> 1 🔀 M 2 🗆 West Virginia Director 212-50-2665 61 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Carroll New Windsor 10e. Street and Number 10g. Citizen of What Country? Funeral 3320 Buffalo Rd. 21776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes : 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 automotive specialist state government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Sampson Moses Garnett Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Windsor, MD 21776 Joyce Ann Moses/ wife 3320 Buffalo Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation: 5/25/2010 Sykesville, MD 21. Signature of the real Service Licenses 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Himonary Embe Lom disease or condition 2 hcxlm Medical resulting in death) Due to (or as a consequence of): Examiner QUADRICLES tendon 10022 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar AY 24 2010 August Signature.

GALVIU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOM AS

acle in

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231660

STONER AVENUE

ENERMIN STER MACYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Catherine Miller 2:15 PM Louise Medical May 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice <u>Baltimore</u> Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 26, 1 **Funeral** 9. Birthplace (State or Foreign 1 M 2X F Months Days Hours Min. Country) Yrs. Director 213-20-8503 84 1925 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Baltimore Nottingham 10e, Street and Number ms 23a or must be r 10a. Citizen of What Country? Funeral 4102 Taylor Avenue Apt #229 21236 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian the Medical Examiner Black, White, etc. ò <u>Ş</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Electronics Assembler Defense traumatic event, Be ge 1 and 2 should be filed nt of Health and Mental H :: If item 27 is marked ot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Herbert Crue Elizabeth Craiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Mason/daughter 7911 Oakdale Avenue Parkville, Maryland 21234 other 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 5/24/2010 Baltimore, Maryland re of Funeral Service Lic Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Cencu onho) Medical Due to (or as a sinsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 2 No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pade performed 2 🗌 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ျှ Itospice this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate 28d. Describe how injury occurred After 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a
Funeral Detect filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number CKNP R149194 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chales

Registrar DHMH 17 Rev 7/2009

State

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MND

21201

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32. Registrar's S

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Gni

31. Date filed (Month, Day,

Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 7 1918 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 578-18-9669 1 ☐ M 2 🔀 F 91 Aug Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exercitival must be notified at once. 10c. City, Town or Location 10a, State 10b. County MD Carrol1 Hampstead Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21074 130 Hanover Pike Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Ezra Bruer Lara Dean Caldwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Conservancy Dr., Madison, Alabama 35758 19a. Informant's Name/Relationship (Type. Print) Charles R. Bruer (nephew) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 5-22-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Meta Stasis ung /Medical Due to (or as a consequence of) **Examiner** 0. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

anenia

32. Registrar's Signature

State Registrar

Frances

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Ann

4a. Facility Name (If not institution, give street and number)

Transitions Health Care

McWherter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

Sykesville

2. Date of Death

May

Day

USA

21

2010 Year

14. Race - American Indian, Black, White, etc.

Specify: white

clerical

4c. County of Death

Carroll

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

3:15am [™]

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? (es 2 100 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) calmadure, Westminster MD 21150

State

Nothin 24 hours after death.

To the Funeral Director; Af

Division of Vital Records,

Registrar

β

Be Completed

Certification: To

Medical

25. Was case referred to medical examiner?

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

1 Yes 2 -No

27. Manner of Death

2 Accident

(Check only

29b. Signature and title of cortifle

31. Date filed (Month, Day, Year)

3 ☐ Suicide 4 Homicide

29a. Certifier

1 Natural

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

1 ☐Yes 2 ☐No

Bradley Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03878 UNK UNK 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 21, 2010 Medical Examiner Bradlev Allen Miller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Valley Road North of Pot Spring Road Lutherville **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Minnesota If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 213-96-3321 Director 45 8/5/1964 Country) 1 X M 2 F Usual Residence of Decedent 10c. City. Town or Location 10a State 10b, County Maryland Baltimore Phoenix IMOOFE, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. rector 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7 Colonial Oaks Court 21131 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Yes _{Specify:} Black 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year ò 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Sales Freestae Surgical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leslie V. Miller, Jr. Erna E. Reiger 19a, Informant's Name/Relationship (Type, Print) 19b. Mailting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Miller / Wife 7 Colonial Oaks Court Phoenix, Maryland 21131 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) partment o Hilltop Service Corp. 5/24/2010 Towson, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility OWSON, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Wedica a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or hijury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical ling physician ar UNPENDED AMENDED Box 68760, IF FEMALE: 23d Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? use Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed: death? 1 🗸 Yes page ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injun 28d. Describe how injury occurred 27. Manner of Death Driver auto fixed object collision May 21, 2010 1 Natural 0027 hrs Division 1 Yes 2 ✓ No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3

0040 hrs

10d. Inside City Limits

1 Yes 2 XNo

Approximate Interval

Between Onset and

Death

Year

Day

29d. Date signed (Month, Day, Year)

May 21, 2010

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Could not be or Town, State) Dulaney Valley Road North of Pot Spring , Lutherville, M determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item/23a)

Assistant Medical Examiner

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla	and / Depa	artment of H	lealth and I	Mental Hyg	giene		
			State Registrar	Cer	tificate of E	Death	F	Reg. No. 2	010 16092	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month May 21		3. Time of Death	
	Medic	al	Margaret Mary Nestor 4a. Facility Name (if not institution, give street and number)		41. O't. T	L			9:50 A ^M	
	Examin	er	Brighton Gardens		North B	Location of Death	1	4c. County of Death Montgomery		
	Funeral	П	5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	Birthplace (State or Foreign Country)	
	Director			8 Yrs.	World's Days	Hours Milli.	April 21	1912	Massachusetts	
	nd at	'n	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation				10d. Inside City Limits	
	haryla 8a-f s tified	ect	Maryland Montgomery		North	n Betheso	l a		1 ☐ Yes 2 🛣 No	
	the h	Ē	10e. Street and Number		10f. Zip Code	1 Declies		10g. Citizen o	f What Country?	
	hwith ns 23, nust l	Funeral Director	5550 Tuckerman Lane #252			0852		Uni	ted States	
_	r deat or iten iiner r		11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - American Indian, ack, White, etc.	
0500-c	safte ral", c Exam	ed by	1 X Never Married 2	1	☐ Yes 2 🛛 No	Specify:		Speci	fy: White	
ה ה	thour unatro dical	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa		kina	16b. Kind of	Business Industry	
7	thin 7%	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	O NOT use retired)		,		1.0	
7	ed wil Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)		Building		or ne (First, Middle, I		<u>al Government</u>	
yland	l be fil lental rked ric ev	ပု	John Nestor				nda Henr			
a S	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a				State, Zip Code)	
 ∑	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Health and Mental Hygiene. The Application of the Hybrid of Hygiene and Hygiene. The Maryland of Hygiene and Hygiene. The Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at		Karen Griffin/Niece			e Drive,	Rockvil	1e, Ma	ryland 20851	
5	Page 1 a ment of H ant: If ite ury or otl		1 XBurial 2 Cremation 3 Removal from State	b. Place of Disport cemetery, crem	sition (Name of natory or other plac	e)	Date	20c. Location	n - City or Town, State	
altillion	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		ven Cemeter		6, 2010	Silver	Spring, Maryland	
0	permit. Departr Imports any inji			Rර් 01530 30	Name and Address bert A. Pur O West Mont	phrey Fune gomery Ave	ral Home, nue, Rockv	Rockvill ille, M	le, Inc. aryland 20850	
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
1	h sician/	10 1	Immediate Cause (Final disease or condition resulting in death) Aspiratio		onia				Onset and Death	
	Medical Examiner		Due to (or as a cons		D - 41					
		ner	if any, leading to immediate Due to (or as a cons		rallure					
	outed nd ransit	kami	cause. Enter Underlying Cause (Disease or linjury that initiated events Coronary		Disease					
	cian a	dical Examiner	resulting in death) Last Due to (or as a cons	. ,						
3	v requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial-transit	edic	d. Esophagea	1 Dysmot	LILLLY					
9	certify anding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ F		Tetonia prognana			23d. D	Date of delivery	
בַּבְּי	death he atte ed for	Sicia	1 Yes 2 No 4 Pregnant at time		Other (specify)	У		N	Nonth Day Year	
5	at the d by tl letach		9 Unknown Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e Did to	hacco lise coi	ntribute to the cause of death?	
L : ດັ່.	signe d be c	d by		J	, ,				3 ☐ Probably 4 ☐ Unknown	
ecords,	v requisited should should	olete					24a. Was a		. Were autopsy findings available	
בַּי	ne lav te has rage 2	Completed					autop:	med? 2 X No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
VII :	ertifica ctor, p	BeC	25. Was case referred to medical examiner?			ace of Death (Chec		225 110		
>	nysic this ce al dire	ရ	1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient 2			4 X Nursing H	ome 5 Reside			
5 ' = :	ding Pnysician; The land. After this certificate hat funeral director, page	sate	27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe ho	w injury occu	rred	
	Atten ar deat ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - Al						ber or Rural Route Number,	
2	ntal or urs afte ral Dir lled in l		building, etc. (Spe				City or Towr			
:	Io the hospital or Attending Priysician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 XCertifying Physician: To the best of my kn (Check 2 Medical Examiner: On the basis of examina only one) 3 Certifying Nurse Practioner: To the best of	ation and/or invest	igation, in my opinio	n, death occurred a	at the time, date an	d place, and d	lue to the cause(s) and manner stated	
:	Vithin vithin comp	2	29b. Signature and title of certifier		29c. License				ed (Month, Day, Year)	
			The Man		D536	91		May 2	1, 2010	
			30. Name and address of person who completed cause of death (H			0 = -			20050	
	Stat	Α	Ajay Reddy, M.D. 3200 Tower 31. Date filed (Month, Day, 1937)	Oaks B1	vd., #11	U, Rockv	ille, Ma	<u>ryland</u>	20852	
	Registra		31. Date filed (Month, Day, Year) 2 4 2010 32. Receptrar's Sign	J. J.	gare					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2010 11:50P M May Physician/ Ostrum Henry Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Year 9<u>37</u> Days May 18, Funeral Country) Tennessee 1 🔀 M 2 🗆 F Yrs. 72 **Director** 214-31-3938 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b County 10a. State Director 1 ☐ Yes 2 🔀 No Union Bridge Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b U.S.A 21791 4225 Bark Hill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Decegent's Osual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) charter bus/ College (1-4 or 5+) Elementary/Seconday (0-12) heavy construction carpenter /driver 10 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) ပ္ Odas Odom William Henry Ostrum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Union Bridge, MD 21791 4225 Bark Hill Rd. Catherine Ostrum/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Paul's Luth. Cem. 5/18/2010 Uniontown, 4 Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of FacilityHartzler Funeral Home Gauss UnionBridge, MD 21791 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Mulinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 3 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760 Records, Division of Vital thin 24 hours after death.
the Funeral Director: After managed filled in by the fun Hospital Tot 5

Baltimore, Maryland 21215-0036

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier MRRCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 Washington Rd., Westminster, MD 21157 Stephen Sikorski

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Roos 4/28/2010 7:40am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1104 Tucker Lane Ashton Montgomery 7. Age (In yrs. 69 last birthday) Social Security Number 280–34–7038 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Days Hours Min 7/3/1940 **Director** OH Usual Residence of Decedent or 28a-f show a notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Ashton XX 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 1104 Tucker Lane 20861 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2XXNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Newsprint Editor Education Be Father's Name (First, Middle, Last)
Elmer Nord 18. Mother's Name (First, Middle, Maiden Surname)
Helen Green ပ 19a. Informant's Name/Relationship (Type, Print)
Philip Roos / Husband $\begin{array}{ll} \mbox{Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)} \\ \mbox{1104 Tucker Lane, Ashton MD 20861} \end{array}$ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or oti Date cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Wauseon Union Cemetery 4 Donation 5 Other (Specify) Wauseon, 21. Signature of Funeral Service Licensee Victor P. 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 Doda Si u 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the me ode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner entially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and defeached for use as the burial-transi Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Mo
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2XXNo completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home SXX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 \square Pending 1XXNatural injury work?
1 Yes 2 No death. Accident
Suicide Investigation within 24 hours after deat To the Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical XXertifyi 29a. Certifier g Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medica Exam r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Tractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse 29b. Signature and the b 29c. License number 29d. Date signed (Month, Day, Year) April 28, 2010 6 30. Name and address pleted cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) **NAY 24 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia	an/	Registrar 1. Decedent's Name (First, Middle	e,Last)					Date of Deat			3. Time of Death
Medical Exami		Joanne	Page S					Month May 11, 20	010	ear	1009 hrs
)		4a. Facility Name (if not institution Maryland General Hos		ber)	1	City, Town, or Location altimore	n of Death		4c. County	of Death	1
Funeral				Age (In yrs. last			der 24Hrs.	8. Date of Birl	th (MM/DD/YYY	Υ) 9. Bir	thplace (State or Foreign
Director		219-40-2515	1 M 2 F	6		Months Days Hou			-1940	Co	untry)
		Usual Residence of Decedent			110.				7.770	1/9/	Aryland
v any		10a. State 10b. County			wn or Location					Ť	10d. Inside City Limits 1 Yes 2 No
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she taitic event, the Medical Examiner must be notified at once		803 Chau	12. Was Deced	lent Ever in U.S.	13. Was D	21217 ecedent of Hispanic O		ify Yes or No-		S A	can Indian, Black,
death v	Funeral	1 Never Married 2 Ma				specify Cuban, Mexica				ite, etc.	,
after o	by F		orced If Yes, Give Year or Dates:			s 2 No specif			Specify	W	hite
hours 'natur Exam	ted	15. Decedent's Education (Special Elementary/Secondary (0-12)	cify only highest grade College (1-4			Isual Occupation (Giv of working life. DO NO			16b. Kind of E	usiness/l	ndustry
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5-0036 iled within 7 Hygiene. I other that	Completed	17. Father's Name (First, Middle,	Last)			18.Moth		irst, Middle, N	l Malden Surnam	e)	
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_ 4 5 5 2		20a. Method of Disposition	vices	20b. Plac	e of Disposition	(Name of cemetery,		Date	20c. Location	- City or	Town, State
Baltimore, sernit. Pages I a Department of He Important: If its injury or other tr		1 Burial 2 Cremation	_	State Cren	natory or other p	Constery	5/2	1/10	Bal Le	. 4	ud
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other Sp. 21. Signature of Fune 1 Pervice		100-	22. Name	and Address of F	lity Will	012311	elisali	Haw	Chapel
M F P F		23a. Part I. Enter the disease, or of failure List only one cause of	poller								
Physician /Medical		23a. Part I. Enter the disease, or a failure. List only one cause of	complications that cause on each line.	sed the death. Do	not enter the m	ode of dying, such as	cardiac or re	spiratory arre	est, shock, or he	eart	
Examiner		Immediate Cause (Final disease or condition resulting in death)				vascular d	isease	compl	icated	by	Death
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	ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence of):							
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Box 68760 e death certificate b the attending physied for use as the bu	N/U	IF FEMALE: 23b. Was decedent pregnant in the	23c. if yes, out	come or pregnan	cy 2 Fetal d		oic pregnancy		23d. Date of Month	_	yay Year
ox 6 ath cert	sicia	past 12 months? 1 Yes 2 ✓ No 9 Unki		t at time of death	~ =	(Specify)					
). Bo) the death: the att	Physician/Me	Part II. Other significant condition	aouruowi		ting in the unde	dvina cause diven in F	Part I	23e Did tol	hacco use cont	ribute to	the cause of death?
P.O. Es that the canada by the edetached		Aspiration	_		_		Gre i.	1 Yes			ably 4 Unknown
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ec law	Completed by							autops perfori 1 V Yes 2	med?	prior to codeath? 1	ompletion of cause of s 2 No
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. The Funcral Director: After this certificate has been signed by the attending physipletely filled in by the funeral director, page 2 should be detached for use as the beautified in the strength of the		25. Was case referred to medical				26.Place of Deat	h (Check only			<u> </u>	5 2 110
Vita hysicia this ca	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpe	atient 2 🗸 ER	/Outpatient 3	DOA Other	Nursing H	lome 5 F	Residence 6	Other	:
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Division of Papital or Attending Phous after death. reral Director: After tilled in by the funeral	Certification:	deterr	not be I	residence		ctory, onice building, e	etc. 28	or Town, St	ate) 803 (haur	ral Route Number, City 1 Cey Ave
Hospit 24 hour Funer ely fil		29a Certifier	ysician: To the best o	f my knowledge, o	death occurred	at the time, date and p					
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical		niner: On the basis of e	examination and/o							
F \$ F 5	ž	29b. Signature and title of certifier		and the state of t	1	29c. License numbe	er .		29d. Date sign		nth, Day, Year)
		pl /	The same of the sa	5/	1))	O.C.M.E.			May 12, 2	D10	
_		30. Name and address of person v Russell Alexander MD.				nn Street, Baltim	nore. MD 2	21201			
St	ate	31. Date filed (Month, Day, Year)		stra's Signature		Jacot, Daitill	. 5. 5, 1710 2				
Regist	w.cc	MAY 2	4 2010	Grane	A for	alas					
DHMH 17 Rev 1/20	001	****		C	RIGINAL				OCME		

DHMH 17 Rev 7/2009

State Registrar

GEOFFREY 31. Date filed (Month, Day, Year) SHEINSELD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2010May 20, Charles Edward Sheehan, Jr. 6:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2211 Edmondson Avenue Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Nov. 7, 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours 91 Maryland 219-03-1671 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married USA 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Sheehan Assoc. LTD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Sheehan, Sr. Teresa M. (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Sheehan, III Son 11690 Laurel Oak Court; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 5/24/2010 Frederick, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Jignature of Funeral Service License 1630 Edmondson Avenue; Catonsville 21228 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final BUCEPHALOPATHY HEPATIC disease or condition resulting in death) Due to (or as a consequence of): IVER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPOTOUSION Due to (or as a consequence of): TESTINAL HEMMORITAGE IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death Day Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARDIOMYOPATH HEMIC 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

ğ

Completed

Be ည MD

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

Health and Mental Hygiene. em 27 is marked other than ther traumatic event, IN-M

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Baltimore, Maryland 21215-0036

Examiner sician and burial-trans attending physician for use as the buria Physician/Medical signed by the atte þ director, page 2 should Completed peen has Be Certification: To After this

Division of Vital Records, P.O. Box 68760,

npletely filled in by the funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t within 2 To the I

20+

Registrar

cal

Medi

25. Was case referred to medical examiner? 1☐Yes 2 No

3 Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature and title

5 Pending investigation

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

F10040017

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

SUITE DOY, CATONSULUS, MO

Scott Four 405 FREDERICHE ROAD,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19^{ay} MΆΫ 20ÏV STEIN 09:55A M MARTIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMORE PIKESVILLE ARDEN COURTS Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours 1472711917 212-18-2581 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County with the Maryland at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No PIKESVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? Funeral items 23a USA 21208 8909 REISTERSTOWN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. o 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Nidowed 4 □ Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) HOME IMPROVEMENT CONTRACTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 STEIN RANKIN permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic (once. RAE SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7488 SEA CHANGE, COLUMBIA, MD 21045 MICHAEL STEIN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State WOODLAWN, MD 4 Donation 5 Other (Specify) BETH TFILOH CONG. 05/21/2010 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or a onsequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 5 Other (specify) Month Pregnant at time of death signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other LIVING 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 IDOA မ this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \quad Yes Certificate: After 1 Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours are deat To the Funeral Director: A completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29c. License numbe May 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valley Road limonium MD 21092 DIVA 2300 Dulaney 32. Registrar's agnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Debra Louise Trivett-Schwartz 2010 10:54 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7853 Sellner Road Lot 13 Jessup Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 □XF Months Days Min. 53 Hours 04/22/1957 216 70 2584 Director Maryland Usual Residence of Decedent show at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f st e notified a Jessup Maryland Anne Arundel 1 X Yes 2 No 10e, Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 7853 Sellner Road Lot 13 20794 U.S. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces? 0 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Year or Dates 3 Widowed 4 Noivorced Specify. White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Fem 27 is marked o ည Raymond Trivett Gladys Dowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys McNeir / Mother 7853 Sellner Road Lot 13 Jessup, Maryland 20794 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 05/13/2010 Bayview Crematory permit. . Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) MINUTES Medical Examiner tre Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor: After this certificate has the funeral director, page 2 s autopsy performed? 2**X** No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 📈 No Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending work? Accident Investigation 2 🗀 No after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ithin the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore 2 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAVOA

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:54 PM orraine Velasco May 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ⊡ M 2 🗹 F Min. Davs Hours (Month, Day, Year) Maryland 215 30 5066 Director Aug 25, 1932 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sidical Examiner must be notified Anne Arundel Glen Burnie Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 7879 Crilley Road Apt. 458 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever Department of Health and Menta Important: If item 27 is marked any injury or other tensors. 2 Reuben Greenstreet Lena Fedo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 - 9th Avenue N.W. Linda Velasco / Daughter Glen Burnie, Maryland 21061 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 05/24/2010 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest by one cause on each line. 23. Part 1. Enter the diseas shock, or heart failure List Interval Between Onset and Death Immediate Cause (Final Physician/ Aurhic Ruptured Aneurysm disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year ☐ Pregnam
☐ Unknown signed by the a 9 Unknown by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one;

Box 68760 P.O. Records, Division of Vital e Hospital or Attending Ph n 24 hours after death. e Funeral Director; After th To the 1 within 2 To the 1

> State Registrar

32. Registrar's Signature

Ha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Jinny

South Greene Street

MO

1992964977

Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 18,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Baltimore,	permit. Pages 1 Department of H Important: if its eny injury or ot snce.		21. Signature of Funeral Service Licens Houn	nouten mo	1530 3	00 West Mont	tgomery Ave	enue, Rockv	ockville, Ind ille, Maryla	nd 20850
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Division	in de	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)	street, ractory, onice	9	City or To	wn, State)	
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,			30. Name and address of person who	completed cause of death	h (Item 23a) (Typ	octville	Dilo 1	-100 D.	of till	MD 11851
1_			rathicia lomski	o Ivay, III)	Signature #	OCKVITTE	TINEJO	IVU) NO	CN/11/C/	IN avoid
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Manth Wooden 201°0 Physician/ Evelvn Ann 9:57p Medical 4b. City, Town, or Location of Death
Westminster 4c. County of Death Carro11 4a. Facility Name (if not institution, give street and number) Examiner Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Allo 3 1922 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 87 1 □ M 2 🔀 F 218-16-2294 MD Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Carro11 Westminster 1 🗆 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21158 10e. Street and Number 510 Lakes Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 Specify: white ier than "natural", c the Medical Exam 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Bessie Fisher Benjamin Hungerford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Lakes Ct., Westminster, MD 21158 Diane Conaway (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery crematory or other place)
Springfield Cemetery 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State Sykesville, MD 5-24-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Harght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dear Immediate Cause (Final Physician/ disease or condition Medica resulting in death) Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a c and I-transit that initiated events Due to (or as a cons resulting in death) Last physician a the burial-1 Physician/Medical Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 St Other (Specify) DNc. House 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manper of Death 28c. Injury at Certificate: Natural Accident work? 5 Pending 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check de signed (Month, Day, Year) 29b. Signature and title of pertific rson who completed cause of death (Item 23a) (Type, Print) Stroot (32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10c, 18 per fh g903 5-24-10 vt.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ <u>1</u>8 2010 9:25 Р CHARLOTTE WAXMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON **BALT IMORE** GILCHRIST HOSPICE CARE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min 1 □ M 2 🛛 F 107087192 Yrs. 88 MA Director 214-18-7836 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 1 Yes 2 No Towson MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 800 SOUTHERLY ROAD, #520 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. or 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE should be man and Mental Hygiene. Specify: 3 X Widowed 4 Divorced Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) COUNSELOR MENTAL HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ MINNER- Minnie COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 6620 PARKWAY ROAD, BALTIMORE, MD 21239 DEBORAH GADSDEN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW CEM. D5/21/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21, Signature of Funeral Service Ligensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 TOCA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Obstructure Polmonan Physician/ disease or condition resulting in death) nonic 0 ars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner it any, reading to immediate cause. Enter Underlying Cause (Disease or imjury Due to for as a consequence of attending physician and for use as the burial-transil Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 10 months?

1 Yes 2 No Month Day Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ oronan 1X Yes terry 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform 1 Yes 2 No certificate Yes 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 5 Pending injury death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the 1 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signa nd title of certifie 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 30, Name and address of person ho completed cause of Balto N. Charles St. WOLF EUSSA State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 \mathbf{P}^{M} 7:17 ANITA HELEN ARNOLD Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner QUEEN ANNE'S HOSPICE OF QUEEN ANNE'S HOSPICE CENTER CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. MARCH 11, MARYLAND 1939 Yrs. 71 **Director** 220-38-5452 Usual Residence of Decedent 10d. Inside City Limits ems 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County with the Maryland Director 1 Tes 2 No QUEEN ANNE'S STEVENSVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Il Hygiene. other than "natural", or items 23a Funeral UNITED STATES 21666 107 TOUHEY DRIVE 13. Was Decedent of Hispanic Ongin? (Specify Yes or Nohours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status traumatic event, the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 2 **X** No 1 Yes 2 þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) within 72 | life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EDUCATION TEACHER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of ည ERMA BISSELL GEORGE SHOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau 18511 ORLANDO DRIVE, CATLETTSBURG, KY 41129 VICKI SHEFFEY/SISTER Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State MAY 7,2010 STEVENSVILLE, MARYLAND STEVENSVILLE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, 106 SHAMROCK ROADD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Dav Month in the past 12 months? ō Pregnant at time of death Unknown the detached P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 1 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed or Attending Physician: The this certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medical Be HOSPICE CENTER examiner? Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 2110 ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: injury work 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined

SUN,

Medical

29a. Certifier

29b. Signature

31. Date filed

only one)

Name and add

and title

certifi

Year 5

ss of person who completed cause of death (Item 23a) (Type, Print)

2108

32. Registrar's Signature

State Registra

ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

anh

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

037131

Orne Clocky MO 2/(

29d. Date signed (Month, Day, Year)

		•	For State Registrar	State of Maryla	nd / Depa		Health and N	Mental Hyg			16105		
	Physicia Medio Examin	al	Decedent's Name (First, Middle, Language) James Larr 4a. Facility Name (if not institution, given the property of the p	y Akers		4b. City. Town. o	or Location of Death	2. Date of Deat Month May 4, 2	2010 Day	Year y of Death	3. Time of Death 11:10 A ^M		
q	Examin		Frederick Memori	al Hospital		Fre	derick			rederic			
	Funeral Director		214-34-2283	Sex. 7. Age (In yrs. 1 Δ M 2 \Box F 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 7,	938	9. Birthp Count	lace (State or Foreign ry) Virginia		
	aryland 3a-f show <u>ified at</u>	Funeral Director	Usual Residence of Decedent 10a. State 10b. County West Virginia Je		City, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 🏋 No		
	h the M a or 28 be not	al Dir	10e. Street and Number	TICISOII C	DIGITION	10f. Zip Code		1	l 0g. Citizen of	What Count	try?		
	ith with ms 23 must	ner	180 Louisa Beall	Lane	16 112 1	25414	4 Hispanic Origin? (Sp	noifu Voc or No	Unite				
9600	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	6	11. Marital Status 1 □ Never Married 2 🕅 Married 3 □ Widowed 4 □ Divorced	Armod Forces?		f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		ce - America ack, White, e v: Wh			
15-(72 hou n "nati fedica	Completed	15. Decedent's (Specify only highest of	rade completed)	(Give	dent's Usual Occu kind of work done O NOT use retired	during most of work	ing	16b. Kind of E	Business Ind	lustry		
212	filed within 7 tal Hygiene. d other than svent, the Me		Elementary/Seconday (0-12)	College (1-4 or 5±)	lile. D	Super			Aut	omobil	le		
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hour it of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, <u>the Medical</u>	To Be	17. Father's Name (First, Middle, Last James Lucas Ake				18. Mother's Nam Ruby E	e (First, Middle, N thel Sne		ne)			
Mar	2 shou th and 77 is m traum:		19a. Informant's Name/Relationship				and Number or Run						
ē,	f Healt f Healt item 2 other		Norma Jane Akers 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	all Lane,		20c. Location				
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery May 7, 2010 Frederick, Maryland 1. Signature of Funeral Service Licensee Keeney & Basford PA Funeral Home										
Ba	Dep Imp any onc		> 16 m /		1473 Ke	eney & E 6 E. Chu	Bastord PA irch St. I	l Funera Trederic	l Home k, Mary	71and	21701		
	Physician/ Medical Examiner		23a. Part 1. Enter the disease or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	racerebra	al Hemorrh a		or respiratory arre	st,		Approximate Interval Between Onset and Death		
09,	ate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last										
. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preging the second of the second o	etal death 3	Ectopic pregnan Other (specify)	су			ate of delive onth	ory Day Year		
ls, P.O.	uires that the signed by ald be detailed	ed by Pł	Part II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying cause g	iven in Part I.				e cause of death?		
Division of Vital Records,	he law requ te has beer age 2 shou	Completed						24a. Was ar autops perform	Sy .	Were autop prior to con death? 1 \(\subseteq \text{Yes} \)	sy findings available npletion of cause of		
talF	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?				lace of Death (Chec		Z (28 NO)	T L les	2 🗆 140		
Ť Vii	Physic this carral dire	욘	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 X Inpatient 2 2 28a. Date of injury	ER/Outpatier		4 ☐ Nursing Ho	ome 5 Reside					
o uc	nding ath. r: After e fune	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Day, Year)	inju r y	wor		zea. Describe no	w sijury occur	red			
Division	tal or Atters after de al Directo	Medical Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		home, farm, str	eet, factory, office		28f. Location (Str City or Town		per or Rural	Route Number,		
	the Hospi nin 24 hou the Funer npleted fill	Medica	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of my kno miner: On the basis of examinat irse Practioner: To the best of i	ion and/or invest	tigation, in my opini death occurred at th	on, death occurred a ne time, date and place	t the time, date an ce, and due to the	d place, and du cause(s) and m	ue to the cau nanner as sta	se(s) and manner stated ted.		
	viti To		29b. Signature and title of certifier	Her Na		29c. Licens	mDD35106	2	9d. Date signe May 4,		ay, Year)		
	16		30. Name and addless of person who	.D. 400 West Seve			ick, Maryla	nd 21701					
п	Sta	e	31. Date filed (Month, Day Year)	7 20 32. Registrar's Sign	ature 🥻	Sares							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 09:27 AM May 10 Robert Andrew Blevins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 North East 12 Blevins Drive 8. Date of Birth (Month, Day, Year, April 5,1 9. Birthplace (State or Foreign Country Bluefield West Virginia 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 1 XM 2 □ F Months Hours Min West **Director** 68 267-62-9270 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No North East Maryland Cecil 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 12 Blevins Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Excavator 12 should be filed wirth and Mental Hygie 27 is marked other r traumatic event, ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Annie Tessa Robert C. Blevins 1 and 2 should b f Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ⁷ 21901 Maryland P.O. Box 16, 12 Blevins Drive, North East, Euna M. Blevins / Spouse Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State May 15,2010 4 ☐ Donation 5 ☐ Other (Specify) Gilpin ManorCemetery Elkton, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis shock, or heart failu Interval Between Onset and Death e. List only one cause on each line Immediate Cause (Final Ph sician/ ears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 4 ☐ Pregnant at time of death g ☐ Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined. City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and timpof certifie 5.10.2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 201Ö 9:30p M May Louretta M. Blair Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5804 Western View Place Mt. Airy Frederick 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year) Dec. 11, 1924 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 □ M 2 😿 F Hours Director 85 216-20-4699 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 ☐ Yes 2 🖾 No Maryland Frederick Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō er than "natural", or items 23a or the Medical Examiner must be Funeral United States 5804 Western View Place death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Public Schools <u>Cafeteria Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Harvev Russell Mellott ngeline Landers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 155. Mt. Airy, Maryland 21771 George Blair Jr./ Son Box Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/6/2010 Mt. Airy, Maryland rospect Cemetery 21. Signature of Fund ral Service bicer 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike. . A. rederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate Interval Between Onset and Death months Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner days Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examin Cause (Disease or linjury The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending 1 X Natural _____ vatural

Accident 2 🗌 No death. neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State) within 24 hours a To the Funeral D Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D0062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 196 Thomas Johnson Drive Suite 135, Frederick, Maryland 21702 Praveen Bolarum, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Lena ŽÖ10 7:45 P M Mae Bev 6 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15014 Newcomb Lane Prince George's Bowie Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye 1 🗆 M 2 🔀 F Months Hours Min. Director 362-36-1108 1936 Mississippi Aua Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinar mines has been injury or other traumatic event, the Medical Examinar mines has Funeral 15014 Newcomb Lane 20716 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married by ☐ Yes 2 ☐ MANo Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: If Yes, Give Specify. 3 X Widowed 4 Divorced Completed Year or Dates Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Registered Nurse</u> Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charley Johnson Fannie Laura Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle A. Dunston/daughter 15014 Newcomb Lane Bowie, Maryland 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/11/2010 Woodbine, Maryland ture of Funeral Service L Coing Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, Pand Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eas disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No nas page certificate | 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Matural 5 Pending injury fter death. 2 No Accident Investigation Director / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar

10

2/012

1460

id address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	artment of Health an rtificate of Death		giene Reg. No.2 () ()	16109		
۳	ŵ		Decedent's Name (First, Middle, Last)		Date of Death 3. Time of E				
	Physici /Medic		Bertha Rose Brester		May 7,	2010 Year	5:45 A™		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of E	Death	4c. County of Death			
	Funeral		Hillhaven Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Adelphi If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Prince G	place (State or Foreign		
- Art	Director		269-09-2422 ^{1□ M 2} F 97 Yrs.	Months Days Hours	Min. (Month, Day November	r, Year) Cou	intry) cinnati, OH		
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits		
	Maryla f shovied at	or	Maryland Prince George's College F				1 ⊠Yes 2 □ No		
	r 28a- notifi	irect	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	untry?		
	th with	Funeral Director	3731 Mar1brough Way	20740		USA			
	tems	nuel	Armed Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Wh:	ite		
21215-0036	2 hou natura ical E	ted	15 Decedent's Education 16a Decedent	dent's Usual Occupation		16b. Kind of Business/Ir			
218	ithin 7 ie. ian "r	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	kind of work done during most of DO NOT use retired)	t working	Own Home			
7	lled will have the her the her the	ပ္		emaker	Name (First Adiable				
Maryland	d be fi	Be c	17. Father's Name (First, Middle, Last) Frederick Strohm		Name (First, Middle, : Troehler	Maiden Surname)			
Ž	2 should be to and Mental is marked or raumatic eve	To		ng Address (Street and Number of		r, City or Town, State, Z	p Code)		
	1 and 2 Health a em 27 is ther trau		Beverly R. Teter / Daughter 3731	Marlbrough Way	, College 1	Park, MD 20	740		
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City or T	own, State		
altimore,	:. Pages tment of I tant: If Ite		4 □ Donation 5 □ Other (Specify) Fort Linco		/21/2010	Brentwood,	Maryland		
Ba	permit. Pages Department of Important: If It any injury or once.		1 : 01 111	2. Name and Address of Facility asch's Funeral		4739 Baltim Hyattsville			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiorespiratory	Arrest			Office and Death		
	Examiner		Due to (or as a consequence of): Cerebrovascular Ac	cident					
	9-	Jer		CIUCHE					
	cuted nd rransit	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events Atherosclerotic Ca	rdiovascular Di	isease				
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of): Hypertension						
387		edical	d. Hypertension						
ŏ	leath certifi attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliv	very		
.O. Box	ed for	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	Ectopic pregnancy Other (specify)		Month	Day Year		
<u>Ч</u>	ires that the de signed by the a be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the ur	ndorbing source given in Deat I	220 Did to	hoose was contribute to	the cause of death?		
Vital Records, P.	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Completed by	Dementia	idenying cause given in Part I.		bacco use contribute to es 2 ☐ No 3 ☐ Pro			
Ö	aw requires been significant to should be shou	olete	Hyperlipidemia		24a. Was a	an 24b. Were auf	opsy findings available		
Re	The law ate has page 2 s	omp	-		— autops perfor 1☐ Yes	med? death?	opsy findings available ompletion of cause of		
Ita	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of	Death (Check only or		20,10		
	Physician: r this certificaral director, I	ဍ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	- 122 1141511		ence 6 □Other (Spec	ify)		
UQ O	After une	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury 1 Accident investigation	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred			
Division or	or Attending after death. Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stre		28f. Location (S	treet and Number or Rui	ral Route Number,		
ă	s after	Serti	4 ☐ Hornicide determined building, etc. (Specify)		City or Tow	n, State)			
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or in and manner, stated.	n occurred at the time, date and provestigation, in my opinion, death	place, and due to the co	ause(s) and manner as date and place, and due	stated. to the cause(s)		
	To the Hosl within 24 ho To the Fun completely i	Mec	29b. Signature and manner stated.	29c. License number		29d. Date signed (Month			
	hw ≥ hw ()		*	D47867		5/7/2			
7	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	, , , , , , , , , , , , , , , , , , ,					
	10		Oney Zuniga, 4701 Randolph Road, Sui	ite #216, Rockv	ille, MD	20852			
	Sta Registr		31. Date filed (Month, Day, Year) A 1 2010 Leaun 32. Registrar's Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g904 6-3-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month Physician/ 27, 7:58 A April Medical Thomas Henry Brooks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Yea April 14, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 🍱 M 2 🗆 F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Funeral 1941North Carolina 69 578-74-7404 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Director 1 X Yes 2 No Forestville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 20747 2311 Timbercrest Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black If Yes, Give 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) 12th Private Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Henry Brooks Novella Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Xavier L Brooks/ Brother 2311 Timbercrest Dr. Forestville, Md. other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 May 10, 2010 1 🗷 Burial 2 🗌 Cremation 3 🗍 Removal from State Cheltenham, Maryland 4 Donation 5 Other (Specify) Cheltenham 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licens 20019 4001 Benning Rd. NE Washington, DC 23a. Part \ Enter the disease, or complications that caused shoc or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAL HEM ORRHAGE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERT ENSION Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 performed' 2 No 1 Tes this certificate 25. Was case referred to medical examiner? Division of Vital the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 4/28/2010 00064986 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:50 A M Physician Russe 11 Corbin May 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cristield Somerset Street Fourth If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** 1**⋈** M 2□ F Months 70 215 -36-0918 April 30, 1940 maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1∰Yes 2 No Cristield Somerset Funeral Director Maryland 10g, Citizen of What Country? 10e. Street and Number 21817 U.S.A Fourth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Be Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) city of Crisfield 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental lem 27 is marked or Cleo Robert Corbin မ permit. Pages 1 and 2 shc.
Department of Health and Mimportant; if item ?? 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Somers Mary Corbin - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5-15-10 Marion Station md. U.m.c Cemetery 5
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) Anthony E. Ward F.H. 21. Signature of Funeral Service Licensee dristield 5+ Core 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after deau...

To the Funeral Director: After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 5-6-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 604-Market 31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ MAY 15^{Day} 2010 **JESSIE** CORNELL 1:05P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11867 DOWES ROAD NANJEMOY CHARLES 5 Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days th, Day, Year) 918 NEW YORK 1 M 2 XF Director JUN. 076-10-5871 Usual Residence of Decedent 28a-f shov 10b. County items 23a or 28a-f sho er must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No CHARLES NANJEMOY MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 11867 DOWES ROAD 20662 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. "natural", or <u>چ</u> 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked or ဂ္ CORNELIUS L. PITCHER EMMA L. BAKER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury PAULA PHELPS/DAUGHTER 11867 DOWES RD., NANJEMOY, MD 20662 20a. Method of Disposition 20b. Place of Disposition (Name of MAY Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, GREENRIDGE CEM 24,2010 SARATOGA SPRINS, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses RAYMOND FUNL.SERVICE, P.A. ON AVE., LA PLATA, MD 20646 cry M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ellander Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🗹 Residence 6 Cother (Specify) 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this : After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? neral Director: A 2 🗌 No hours after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PRITCHETT M GRANGE AVE. LA PLATA, MARYLAND 118 .D

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30 Day 2010 **Physician** 2321 Howard L. Cropper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 21 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)}945 **Funeral** Days Min Virginia 1**√** M 2□ F 226-58-8527 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be mutified at 1 ☐ Yes 2 X No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 and 2 should be filed within 72 hours after death with USA 21401 1501 B Cedar Park Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces.

1 Types 2 No
If Yes, Give
Year or Date 963-68 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) 12th College (1-4or 5+) Naval Academy Librarian 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Unobtainable Venzie Cropper ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Annapolis, Md. 21401 1501 B Cedar Park Rd. permit. Pages 1 and :
Department of Health
Important: If item 27
any Injury or other tr.
once. Sylvia D. Cropper(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-10-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winhame Red Addes of Reilisons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. φ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No ours after death. leral Director: A filled in by the fi death. 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the I (Month, Day, Year) 29c. License number D16376 Name MOINA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 May 06:05 PM Selma Augusta Cain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Rising Sun Calvert Manor Healthcare Center 9. Birthplace (State or Foreign Cou**North East** Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** (Month, Day, 1 🗆 M 2 💢 F Director 216-07-2660 VOV. Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 Yes 2 No North East Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 United States 418 East Cecil Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. 3 ₹ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty <u>Beautician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Floyd H. White Elsie Carlson 1913 Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code)
Spotsylvania, Virginia 22553 19a. Informant's Name/Relationship (Type, Print) Patricia L. Craig / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State North East United Methodist Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) North East, Maryland Signature of Europal Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final Physician/ Unbrown Holenocarcinoma of Luna disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t (Month, Day, Year) injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and D0023322 5.10.2010 High St, Eletur MD21921. Sachder-s-MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May Day 10 Year 2010 8:38 PM Physician/ Matthew Cline Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore University of Manyland Medical Center 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) March 2,1978 Social Security Number Mary Land Days **Funeral** 1 🏹 M 2 🗆 F 220-04-9038 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f shov 10a. State and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, <u>the Medical Examiner must be notified at</u> 1 🗌 Yes 2 💢 No with the Maryland Director Hagerstown Washington County Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Completed by Funeral 21742 819 Interval Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after death Black, White, etc. 11 Marital Status White 1 ☐ Yes 2 🔀 No If Yes, Give 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 3 🗌 Widowed 4 🔲 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Restaurant Elementary/Seconday (0-12) Cook 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Kimberly Lea Cline Cordell ည Philip James Richard Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) Interval Rd. Hagerstown, MD 21742 819 Kimberly L. Cordell-mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 5-12-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 331 Fastern Blvd. North Hagerstown, eny 23a. Part 1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or that failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Due to (or as a consequence of) 1 day Medical resulting in death) Prosthetic valve endocarditis **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Year 23b. Was decedent pregnant Month Day Live Birth 2 Fetal deatPregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No n signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ۾ Completed 24b. Were autopsy findings available prior to completion of cause of death? is certificate has been si director, page 2 should I 24a. Was an autopsy performed Yes 2 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 M No 1 Yes within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. 28d. Describe how injury occurred 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Natural 5 Pending 1 Tes 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation
6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide
4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospital Medical 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 10,2010 1992964977

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Jinny Ha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18:56 P.M. Cane UR. 2010 Webster May Honiss /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pocomoke City Worcester Haleys If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 ☐ F 78 Yrs. 219-36-9371 January 31, 1932 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and injury or other traumatic event, the Medical Examinar and December 23 or 28a-f show once. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ¥Yes 2 ☐ No Maryland Worcester Pocomoke Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21851 12. Was Decedent Ever in U.S. Armed Forces? Haleys Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Neyes 2 No If Yes, Give /952-54 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) : Iman Pocomoke City Counci 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Honiss. W. Annie Cane 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Poconoke City md 21851 Haleys Miriam J. Cane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5-8-10 Pocomoke md. Shiloh U. M. C. Cometery 4 □ Donation 5 □ Other (Specify) E. Ward FiH 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Anthony 30634 Ave. Princess Anne, Md Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagl line. Approximate Interval Between Onset and Death Immediate Cause (Final 46 month Physician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, it is to be a first of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by Kaile 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No certificate Physician: 25. Was case referred to medical examiner? director. 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Certification: To this funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Scribe 31. Date filed (Month, Day, Year) State Registrar

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ı	Physicia Medic		1. Decedent's Name Brenda		I	ee			De	Bow				2. Date of D	- 1 D	• • •	Year OIO	3. Time of [Death A
	Examin		4a. Facility Name <i>(if</i> Washingt	on Cou		lospi	tal		_	Hag	erst			0	V 4c. County of Death Washingt				
	Funeral Director		5. Social Security No. 219–72–86	529	6. Sex 1	2 💢 F	F 3. Age (In yrs. last birthday) Trs. Months Days Hours Min. Sept. 95.							1959		olace (State or the Land	Foreign		
	and show	o	Usual Residence of 10a. State	Decedent 10b. County			100	City, Tov	vn or Loc	ation								10d. Inside City	y Limits
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	ms 2	Funeral	305A So	uth An			dent Ever i	n U.S.	13. V		1734 ent of His		igin? (Spe	cify Yes or No)-			an Indian,	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with jujury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marr		rried	Armed For 1 Yes If Yes, Give Year or Da	ces? 2 X No	., 0.0.		Yes, spec				ecify Yes or No Rican, etc.)			k, White, Whi	etc.	
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	Hygie Hygie other	Be C	12 17. Father's Name (First, Middle,	Last)				веац	ticia	in	18. Moth	er's Nam	e (First, Middle					
lan	l be fill lentai rked c	욘	John Al		,							Ion	a A.	Stone	r		_		
Maryland	should and N is ma aumal		19a. Informant's Na	ame/Relations	hip (Type, F	Print)		19	b. Mailin	g Address	(Street a	nd Numb	er or Rura	al Route Numb	er, City	or Town, S	tate, Zip	Code)	
	and 2 stealth		Danielle		erett	/Daug					_	tieta		., Fun				21734 own, State	
Baltimore,	Page 1 anent of hant of hant. If ite		20a. Method of Disp 1 Durial 2 4 Donation	Cremation	3 ☐ Rem Specify)	oval from	State		ery, cren	natory or o	ther plac			Date / 2010		niths	•		
Balt	permit. Departr Imports any inji		21. Signature of Fu	neral Service	Licensee	พ				Name an				lest Ha				-	2
	Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List (Final	r complicat only one ca	Due to (aused the ch line. Characteristics are as a cor	death. Do	not ente	\	e of dying			n Ce (Approximate Interval Betw Onset and D	veen
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% %	te be executed nysician and ne burial⊹transit	dical Examiner	Cause (Disease or that initiated event resulting in death)	iinjury s	c	Due to (or as a cor	nsequence	e of):										
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		1 Live	come of pr Birth 2 nant at time	Fetal dea] Ectopic] Other (sp		у				23d. Dat Mo			ear
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n of	nding Ph tth. : After thi e funeral		27. Manner of Deat 1 Natural 2 Accident	5 Pendi		28a. Date (Mont	of injury h, Day, Yea		. Time of injury	M 2	8c. Injury work 1 \Box	≀at ? Yes 2 □		28d. Describe	e how inj	ury occurre	ed	-	
Division of Vital Records,	al or Atter s after dec al Director ed in by the	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ			of Injury ng, etc. (Sp		farm, stre	eet, factor	, office			28f. Location City or To			er or Rura	i Route Numbe	er,
	ne Hospit n 24 hour ne Funera pleted filla	Medical	29a. Certifier 1 (Check 2 only one) 3	Certifyin	Examiner:	On the bas	is of exami	nation and	or invest	igation, in	my opinio	n, death o	ccurred a	nd due to the o t the time, date ce, and due to	and place	ce, and due	to the ca	ause(s) and mar	nner stated
	To the vithing committee of the committe		29b. Signature and	title of certifit	1					290	. License	number XO 8	654	/	29d. D	nate signed	1 (Month,	S Z	010
	10		30. Name and addr	ress of person	who comp	leted caus	e of death	(Item 23a)	(Type, F	rint)	a ma	201	Dr.	Han	£ 15	town	v m	B Z	742
	Sta	te	31. Date filed (Mont	h, Day, Year)	1	32. R	egistra S	Signatura	Her								7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month 3^{Day} Physician/ 2010 8:50 Рм Dona Deyton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 2100 Whitehall Road, Apt. 8. Date of Birth (Month, Day, Year) Aug. 6, 1924 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 🖾 F Months Days Hours North Carolina Director 85 412-42-1776 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at with the Maryland Director 1 X Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 21702 1026 Taney Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ※ No Black, White, etc. ş 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Textiles / Leather 10 Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever ပ Geneva Bennett Jes Willard Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2100 Whitehall Road, Apt. BA, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Bruce Deyton / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7, 2010 cemetery, crematory or other place)
Resthayen
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature Uneral Se e Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate
Interval Between
Onset and Death
Days complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final Failure to Thrive Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Months Dementia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 2 10x No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 bx N 25. Was case referred to medical 26. Place of Death (Check only one) Be Son's_{Home} examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Yes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Tagtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Chround

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Praveen K. Bolarum, M.D.

31. Date filed (Month, Day, Year,

D 62223

196 Thomas Johnson Drive, Frederick, MD 21702

May 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death pril Physician/ Robert Louis Drayton 30% 2010 12:30PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Oxon Hill 6015 Livingston Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 💢 M 2 🗆 F Hours Min. (Month. Day, Year, Director /24/1934 266-46-4477 Georgia Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County Director MD Prince Georges Oxon Hill 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? by Funeral USA 20745 6015 Livingston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black h and Mental Hygiene.

7 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator Self-Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve P Clarence Drayton Josephine Whitehead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 Annette Burgess/ Daughter 6015 Livingston Road Oxon Hill MD Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Lincoln Memorial 05/10/2010 Suitland MD 4 🗆 D nation 5 Other (Specify) 22. Name and Address of Facility Dunn&Sons Si thre of Funeral Service 5635 Eads St. NE Washington DC 20019 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus ediate Cause (Final Physician/ ease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day ☐ Yes 2 ☐ No s been signed by the same should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performe 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the t 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 20010 ennis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 21:56 Elizabeth Henry Espinosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day) January I Missouri 1 □ M 2 🛣 F Hours Director 500-30-9967 95 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10b. County be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗓 No Buckeystown Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 21717 United States 6817 Buckingham Lane Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: "natural", 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natur ury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Department Store 4 Public Relations Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Helen Dorothy Pugh Leslie Sherman Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 68, Buckeystown, Maryland 21717 John Espinosa / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important: It any injury of May 20, 2010 Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Keeney and Basford PA Funeral Home
106 F. Church Street Frederick M. Maryland 21701 Church Street. Frederick. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Sersis Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the detached g Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed?

1 Yes 2 X No has 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) To the Hospital or Attending X Natural 5 Pending 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License numbe 29d. Date signed (Month, Day, Year) May 17, 2010 D58597 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

M.D.

32. Regist

Shahryar Davari,

31. Date filed (Month, Day, Year

10110 Molecular Drive, Suite 206, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SERM Physician 2010 0 Lou Ella Ellis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMOre None AGNES HEALTheare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6 Sex 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 □XF 86 WV 236-24-8360 07/27/1923 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. 10d Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 □Yes 2 TXNo Catonsville Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States N230 709 Maiden Choice Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 □Yes 2X No Specify Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16h Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Elizabeth Evans Winton Wiley Armstrong ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 709 Maiden Choice Lane N230 Catonsville, MD 21228 Richard Ellis - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksville, MD 05/13/2010 St. Louis Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Sign rure of Funeral Service Licensee M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Atherosilesot **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and for use as the burial-trai Due to (or as a consequence of) attending physiciar Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🔏 No 5 Other (specify) detached 9 Unknown Ö 9 Unknow signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The law requires been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed Yes 2 1 ☐ Yes 2 🗆 No 1 ☐ Yes certificate 26. Place of Death (Check only one) or Attending Physician; 25. Was case referred to medical Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 2 No Hospital: 2ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient this (Certification: To ot 28d. Describe how injury occurred 28b. Time of funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury After (Month, Day, Year) Injury 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No Il Director: A death. 2 ☐ Àccident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 | Homicide after within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier procertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 19b. Signature and title of certifief 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature.

0 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
George Dewey 2. Date of Death Evans Jr. Physician/ Month Year Medical 05 2010 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death **Funeral** If Under 1 Year 8. Date of Birth 7. Age (In vrs. last birthday If Under 24 Hrs Sex 1 🌠 M 2 🗌 F 9. Birthplace (State or Foreign Months Days Min. 0871371927 Director 213-22-8169 82 Yrs. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland De artment of Health and Mental Hygiene.

Inn ortant: If item 27 is marked other than "natural", or items 23a or 280.1-1-1-1 on items 200.000.000 on e. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1030 Heron Court. 21804 LISA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates, Navy Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) operations manager oil company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Morris ဂ္ George Dewey Evans Sr. 19a. Informant's Name/Relationship (Type, Print)
alice Lee Evans/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 Heron Court, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Springhiil Memory
Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/7/2010 Hebron, MD orgina ure of Funeral Service Licensee HOTTOWAY TUTETAL Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CULP NN Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or impury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death should be detached Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident 2 🗌 No Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) g mp 0 NA

Registrar DHMH 17 Rev 7/2009

State

30. Na

me a

31. Date filed (Month, Day,

d address of person

completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

32

10-03289 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John English, Jr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ April 28, 2010 Medical Examiner John English, Jr. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 9008 Ridgewood Drive Fort Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Sociał Security Number 6. Sex **Funeral** Months Days Hours Director 12/11/1941 68 233-64-8432 1 M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10a. State 'n Fort Washington item 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at once. Prince Georges IMOCE, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygène.
Int: If item 27 is marked with a marked 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20744 **NZA** 9008 Ridgewood Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 Yes 1 Yes 2 No specify: Specify: If Yes. Give Year 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Lucent Technologies System Technician 3 75 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Erma Mitchell John English, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9008 Ridgewood Rd., Ft. Washington, MD 20744 Edith B. English / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Cheltenham, MD 05/07/2010 Veterans Cemetery Donation 5 Other Specifi 22. Name and Address of Facility Strickland Funeral Services Rd., Camp Springs, MD 20748 Allentown or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease Physician failure. List only one cause on each line Marie a. Intraoral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last tending physician and use as the burial - transit The law requires that the death certificate be executed ca AMENDED UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live hirth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the att be detached for Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part t P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been autopsy performed page ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self FOUND Division Natural 1 Yes 2 ✓ No Pending 24 hours after death. Apr 28, 2010 1956 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 9008 Ridgewood Drive, Fort Washington, MD determined (Specify) Basement Homicide

10 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year State Registrar

29b. Signature and title of certifie

29a. Certifier 1

Medical

Assistant Medical Examiner

ORIGINAL

and manner stated

10

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3. Time of Death

2011 hrs

ШV

10d. Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Day

29d. Date signed (Month, Day, Year)

April 29, 2010

prior to completion of cause of death?

Country)

Black

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of N	1arylan	-	artment of I tificate of I			lental Hy	giene	9		
			Registrar 1. Decedent's Name (I	First, Middle, La:	st)		Cer	uncate or t	Deair		2. Date of Dea	Reg. No	<u>o. 2 ()</u>	10	16124
	Physicia		Ruth	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	 Caltrid	۵r		Frank			Month May	1 Da	ay 20	ear 10	3. Time of Death 7:40 A M
2	Medic Examin		4a. Facility Name (if no	ot institution, give		<u> </u>		4b. City, Town, o		n of Death	Пау		c. County of		7:40 A
			916 Saint	: Clair	St.			Hagers	town				Washi	ngto	on
	Funeral		5. Social Security Num		DM 21VE		st birthday)	If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min.	8. Date of Birt	th v. Year)	9	J. Birthp Count	lace (State or Foreign
	Director		215-14-157 Usual Residence of De	/3		88	Yrs.			Sept.				ýland	
	land shov d at	tor		0b. County		10c. City	, Town or Lo	cation						10	0d. Inside City Limits
	Mary 28a-f otifie	Director	MD	Washing	ton	H.	agerst	own							1 🏋 Yes 2 □ No
	th the 3a or tbe n		10e. Street and Number					10f. Zip Code				10g. Ci	itizen of Wh		iry?
	ath wi	Funeral	916 Saint	Clair S	12. Was Decedent	From le 11 C	140.34	21742		N-1-1-0 (0	16 - 1/2 = N -		U.S.		
က္	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	 Marital Status Never Married 	2 X Married	Armed Forces:	?	If	Vas Decedent of H Yes, specify Cuba	an, Mexic	an, Puerto F	Rican, etc.)		14. Race - Black,	America White, e	
Ŏ	ırs aft ıral", I Exal	edk	3 Widowed 4	Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2X No	Specia	fy:			Specify:	Whi	te
2-(2 hou " natu edica	Completed	(Specif	15. Decedent's E	ducation ade completed)			ent's Usual Occup		ost of workin	a	16b. F	Kind of Busi	ness Ind	ustry
121	thin 7 ene. • than he M	Som	Elementary/Second	day (0-12)	College (1-4 or	5+)	life. Do Teac	O NOT use retired)				E.	J + +	-	
d 2	filed wi al Hygid d other	d)	17. Father's Name (First	st, Middle, Last)	יי		Teac	Her	18. Moi	ther's Name	(First, Middle,		ducati	LOII	
ılan	f be fi fental rked tic ev	P P	Samuel Ca	altrider						Saub]		,,,aidoli	Garriamoj		
lary	should be file h and Mental I 7 is marked o raumatic eve		19a. Informant's Name	e/Relationship (T)	ype, Print)		19b. Mailin	g Address (Street	and Num	ber or Rural	Route Number	r, City oi	r Town, Stat	e, Zip Co	ode)
≥,	ind 2 selection may be the contraction of the contr		Janko Fra		and			aint Cla	ir S	t., Ha	agersto	wn,	MD 2	2174	2
Baltimore, Maryland 21215-0036	ge 1 a nt of H		20a. Method of Dispos 1 ☐ Burial 2X	Cremation 3	Removal from State	20b. Pl		sition (Name of natory or other plac	ce)		ate	20c. L	ocation - Ci	ty or Tov	vn, State
<u>ti</u>	urtmer urtant ortant njury		4 Donation 5		**	Smi		g Cremat		5/18/			nithsh		
Ba	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.	4 0	21. Signature of Funer	al Service Licens	see			Name and Address 01 Penns							•
			23a. Part 1. Enter the	disease, or com	plications that cause	d the death							S LOWII,	100	Approximate
	Inysician/		Immediate Cause (Fin disease or condition		ne cause on each lir	ne.	A (A) (A)	0							Interval Between Onset and Death
	Medical Examiner		resulting in death)		a. Due to (or as	a consequ	ence of):	Conce							6 months
		<u>.</u>	Sequentially list condi	litions,	b. —									_	
0	ed isit	Examiner	if any, leading to imme cause. Enter Underlyin Cause (Disease or imp	ing 🔣	Due to (or as	a consequ	ence of):								
Dp.	xecut	Exa	that initiated events resulting in death) Las		c. Due to (or as	a conseque	ence of):							+	
0	icate be executed I physician and s the burial-transit	edical			d										
8760	tificate ng phy as th	Med	IF FEMALE:										"		
× 68	eath certific attending p I for use as		23b. Was decedent pre in the past 12 mg	egnant	23c. If yes, outcome 1 Live Birth	2 Fetal	death 3 [Ectopic pregnance	су				23d. Date of		
Box	e deat the at hed fo	ysic	1 Yes 2 1		4 ☐ Pregnant a 9 ☐ Unknown	at time of de	eath 5	Other (specify)					Month	[Day Year
Ö.	requires that the de been signed by the should be detached	F	Part II. Other significa	ant conditions co	ontributing to death	but not resu	Ilting in the ur	nderlying cause giv	en in Par	t I.	23e. Did to	bacco u	use contribu	te to the	cause of death?
S, F	lires the signer of the signer	d by									1 🛂 🛪	es 2	□ No 3	☐ Proba	ably 4 🗆 Unknown
ord	v requ	Completed									24a. Was a				sy findings available
3ec	he law ite has age 2 ;	mo.				400					autop: perfor 1 Yes	med?_	dea		npletion of cause of
a	nysician; The lavins certificate having certificate havinges?		25. Was case referred t	. 1				26. Pl	ace of De	ath (Check o		2 1/10	0 12	res z	: L NO
Ž	Physic this ce	၉	1 ☐ Yes 2 ☑ N	No			ER/Outpatien	3 DOA Othe	er: 4 🗆 1	Nursing Hom	ne 5 💢 Reside	ence 6	Other (S	Specify)	
n of	ding F th. After 1 funera	Certificate:		5 Pending	28a. Date of inju (Month, Da	ıry ıy, Year)	28b. Time of injury	28c. Injury work	?		3d. Describe ho	ow injur	y occurred		
Siol	Attenc death ctor.	ij		Investigation 6 Could not be	a	urv - At hor	ne farm stre	M 1 🗆	Yes 2		8f. Location (St	troot on	d Number o	r Duml C	Pouto Number
Division of Vital Records, P.O.	al or / s after I Dire		4 L Homicide	determined	building, et		,,	ot, tactory, office		2	City or Town			nurair	obte Nurriber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 🗹	Certifying Phys	sician: To the best of	f my knowle	edge, death o	ccured at the time,	, date and	place, and	due to the cau	ıse(s) an	nd manner a	s stated	. ,
	the H hin 24 the Fi	Σ	only one) 3 🗆	Certifying Nurs	e Practioner: To the	best of my	knowledge, d	eath occurred at the	e time, da	te and place,	and due to the	d place cause(s	, and due to s) and manne	the caus er as stat	se(s) and manner stated.
	5 wit		29b. Signature and title	₃ of certifier	0. / 4			29c. License		1 5			te signed (M	onth, Da	ıy, Year)
		-	20 Name and address	ef 4.	mun	M touth (Itam)			716	61			5/17	/10)
	10		30. Name and address	N Nerspi who c	ompleted cause of o	ream (item :	zsa) (Type, Pr	110	100 1	rad	Can	w/ /-	1 6	٤	when the
	Stat	e	31. Date filed (Month, E	Day, Year)	32. Registr	ar's ignatu	falle	1	- 200	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		710	J W	701	01-1-1
	Registra	r	MAY 2	4 2010	Lecure	Ja. 1									

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	٤	State of	Marylan		artment of I <i>tificate of I</i>		nd Mental Hy	/giene Reg. No. 20	10 1612	1.50	
	Physicia Medi		1. Decedent's Name (First, Joseph Pe	Middle, Last) ter Ferace)					2. Date of D Month May	eath	3. Time of Death 7:50 PM	И	
-	Examir		4a. Facility Name (if not inst 5673 Crabapple	itution, give stree Drive	t and numbe	er)		4b. City, Town, o	r Location of colors		4c. County of		_	
	Funeral Director		5. Social Security Number 084-12-5904		2 🗆 F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		rth av. Yea <i>r)</i> 15, 1920	Birthplace (State or Foreign Country) New York	n	
	land show d at	ţōr	Usual Residence of Deceder 10a. State 10b. C	ounty		10c. City	, Town or Loc	cation				10d. Inside City Limits	3	
	ne Mary or 28a-f notifie	Direc	Maryland 10e. Street and Number	Frederick				Frederi 10f. Zip Code	.ck		1 ☐ Yes 2 🗷 N			
	h with th	Funeral Director	5673 Crabapple	Drive				Tol. Zip Code	21703			tes of America		
9800	of filed within 72 hours after death with the Maryland tal Hygiene. So of ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ě	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div	Married	Was Decede Armed Force 1 K Yes 2 If Yes, Give Year or Dates	□ No 194	42- "	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, , White, etc. White		
215-(רסל 27 ה san "nat Medica	Completed	(Specify only	ecedent's Educat highest grade co	ompleted)		(Give k	ent's Usual Occup ind of work done of NOT use retired)		f working	16b. Kind of Bus	iness Industry		
1212	filed within 72 al Hygiene. J other than " vent, the Med	Be Co	Elementary/Seconday (0 17. Father's Name (First, Min		College (1-4 o	or 5+)		rance Agent			Insura	ince	_	
Maryland 21215-0036		10	Francis Fera						18. Mother's	s Name (First, Middle, Osina Alfano	Maiden Surname)			
, Mar	C1 E F 5		19a. Informant's Name/Rela Catherine Fe				19b. Mailin 5673 (g Address (Street a	and Number of Prive, F	r Rural Route Numberederick, Ma	er, City or Town, Sta	nte, Zip Code) 3		
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 🛣 Burial 2 🗆 Crem 4 🗆 Donation 5 🗆 O	ation 3 Rem	oval from Sta	ate C6	emetery, crem	sition (Name of atory or other place t Cemetery		City or Town, State				
Balti	permit. F Departm Importa any inju		21. Signature of Funeral S	nsee	>	M01433	22 K	Name and Address Reeney & Ba	s of Facility	y 20, 2010 .A. Funeral	Home		_	
			23a. Part 1. Enter the disea shock, or heart failure.	se, or complicati	ons that caus	sed the death	1	.06 East Ch	urch St	reet, Freder	<u>ick, Maryla</u>	Approximate	_	
	Pnysician/ Medical	()	Immediate Cause (Final disease or condition resulting in death)	a		<n a<="" th=""><th>5161</th><th>Kil Kil</th><th>lary</th><th>Diver</th><th>e</th><th>Interval Between Onset and Death</th><th>(</th></n>	5161	Kil Kil	lary	Diver	e	Interval Between Onset and Death	(
	Examiner	ı.	Sequentially list conditions,		Due to (or a	as Conseque	ence of):	750	5			Venis	,	
Q	rted	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	<	Due to (or a	as a couseque	ence of):				13			
)\tag{7}	icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	Due to (or a	as a conseque	ence of):	· · · · · · · · · · · · · · · · · · ·						
8760	ificate b ng physi as the t		IF FEMALE:	d			_						=	
Division of Vital Records, P.O. Box 68760	• Hospital or Attending Physician: The law requires that the death certific 24 hours after death. • Funeral Director: After this certificate has been signed by the attending peter filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No	1 1	Live Birt	ne of pregnan h 2 Fetal t at time of de n	death 3 🗌	Ectopic pregnanc Other (specify)	У		23d. Date Mont	· ·		
, P.O	es that tigned by	by	Part II. Other significant co	nditions contribu	iting to death	but not resu	Iting in the un	derlying cause giv	en in Part I.			ute to the cause of death?		
ords	v require s been s should	Completed	(11600)	(-) A	too.	1/01	1) 1	in se		1 24a. Was		Probably 4 Unknown	_	
Rec	sician: The law scrifticate has t			74	1776	7		.,		— autor	priormed2 dea	or to completion of cause of ath? Yes 2 No		
Vita	s certific	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ ₩6	dical Hospi	tal:	ationt 2 🗆 E	R/Outpatient	Otho		Check only one)			_	
on of	nding Phy ath. :: After thi e funeral o			ending vestigation	Ba. Date of ir (Month, E	njury 2	28b. Time of injury	28c. Injury work	at	28d. Describe h	ow injury occurred	Specify)	_	
Division	tal or Atters after der al Director ed in by the	l Certificate;		could not be etermined		njury - At hometc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
	To the Hospital or a within 24 hours afte To the Funeral Dire completed filled in t	Medical	CHECK Z LI MEG	icai examiner: U	n the basis of	r examination :	and/or investic	iation in my obinioi	n death occur	ce, and due to the car red at the time, date a d place, and due to the	nd place, and due to	the caucale) and manner state	ed.	
	To t To t		29b. Signature and title of ce		· ()	1	MA	29c. License D1642	number		29d. Date signed (M		Ī	
	12		30. Name and address of pe	rson why comple	ted cause of West: N	death (Item 2	23a) (Type, Pri	nt) rederick,	Marvland	1 21701	3/10/10			
		State 31. Date filed (Month, Day, Year) 32. Registrar's Signature												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A^M John Edward Grimes, Sr. May 6 1:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital <u>Rockville</u> Montgomery . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 X M 2 □ F Months Days Hours Min. Year) Director 214-30-1187 79 Feb. Maryland Usual Residence of Decedent fshov 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 No Maryland Gaithersburg Mongtomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7435 Kilcreggan Terrace 20879 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. by 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or DatesKorean War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Heavy Equipment Operator</u> Construction Company should be filed w Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Wilson Grimes Mary Summerfield . Page 1 and 2 shou tment of Health and tant: If item 27 is n 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona Gail Grimes, wife Kilcreggan Terrace, Gaithersburg, MD 20879 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 5/8/2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Moriah Methodist Cemetery Blue Knob, Pennsylvania 21. Signature of Funeral 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Part . Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final Physician/ disease condition resulting in death) Severe Cardiomyopathy Medical Due to (or as a consequence of) Examiner Severe Aortic Regurgitation Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown detached 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, The law requires 1 🗌 Yes 2 No 3 Probably 4 X Unknown Completed been signated 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural (Month, Day, Year) 5 Pending

or Attending Physician; Division

death within 24 hours after death

To the Funeral Director: /

Accident

3 Suicide
4 Homicide

State Registrar

Medical

Hospital

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067386 May 6, 2010

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

9901 Medical Center Drive, Rockville, Maryland Sonia John, 20850 31. Date filed (Month, Day 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 7/2009

			Pleas	e Type or Print in Amend Ite State of Maryla	Black Indel	ible In G904	k. Ensure	All Copie	es Are Leg	jible.	
_		,	State Registrar		Certific				Reg. No 20	10	16127
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	Examir		4a. Facility Name (if not institution, g	ive street and number)	4b. 0	ity, Town, o	or Location of Death	·	4c. County	of Death	
	Funeral Director		5. Social Security Number 6.	Sex Age (In yrs.		der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of B		9. Birthp Count	ace (State or Foreign "Y) PA
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	within 72 hours after death with the Maryland giene. than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 6485 Davis	Street	10f.	Zip Coble	33/-		10g. Citizen of	What Count	ry?
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Maryland	ould be id Menta marked matic e	2	Patrick OL 19a. Informant's Name/Relationship	Uch S	40b Maillea Add	(04	and Number or Ru	rinz	mc	O I LOT	ols
	ge 1 and 2 should be filed within 72 hours after to of Heath and Mental Hygiers in filed the fall filed is marked other than "natural", or other traumatic event, the Medical Exam.		Shown Giacol	ble Son	6485 1)avis	Sheet	12)	oleague	UA	23336
Raltimore	Page 1 a nent of H ant: If ite ury or ot	ı	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	Place of Disposition (cemetery, crematory)			Date 10/2010	20c. Location		vn, State
Balti	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service Lice			and Addre	ss of Facility	10/2010		eteagi	e, VA 23336
lu			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the dea	th. Do not enter the m		TILLIAN TO	or respiratory a	rrest,	7 CIN	Approximate Interval Between
088	Ph sician/ Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	mente	2					Onset and Death
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₩.₩ 68760	certificat nding ph	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d Da	te of deliver	V
lh Box	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the bi	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🔲 Ectop death 5 🗍 Other		эу ————————————————————————————————————				Day Year
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Oivision of Vital	l or Atte after de Directo I in by th		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, fact y)	ory, office		28f. Location (City or To	Street and Number	er or Rural i	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2	nysician: To the best of my know miner: On the basis of examination	on and/or investigation.	in my opinio	on, death occurred a	at the time, date	and place, and due	to the caus	e(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certifying Nu 29b. Signature and title of certifier	urse Practioner: To the best of m	y knowledge, death oc	curred at the	e time, date and pla	ce, and due to the	ne cause(s) and ma 29d. Date signed	anner as sta d (Month, D	ed. ay, Year)
	10		30, Name and address of person who	RAU R. ISA completed cause ondeath (Iter	RAL) n 23a) (Type, Print)	154	1422		5-	7 -	10
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	Stat Registra	.0	MAY 10	2010 Francis Signal	B. Agar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis Gaddi Emilio aka John Gaddi 05 2010 0113 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson **Baltimore** Social Security Number Funeral 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🛛 M 2 🗆 F Months Hours (Month, Day, Year) 05/30/1928 Director <u>577-64-5865</u> 81 Brentwood, Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It is a 23a or 28a-f sho iften 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6334 Cedar Lane 21044 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Decedent Ever in C.S. Armed Forces?
1 1x Yes 2 N1950—
If Yes, Give Year or Dates. 1952 Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 - Widowed 4 - Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Baker **Priv**ate Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Abel1 Madeline <u>Dario B. Gaddi</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Fayette Road Kensington, MD Ruth Burke - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or c ₽ 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 05/07/2010 Brentwood, MD Ft. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 3401 Bladensburg Road Brentwood, MD 20722 1 cour 23a. Part 1 Enter the disease or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ NEUMONI DAUS Medical resulting in death) Examiner PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy death? 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) nours after death.

neral Director: After this or
dilled in by the funeral dire 1 Yes 2X No ၉ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide 24 hours Medical 29a. Certifier 1 🔆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29c. License number **D** 64395 MAN 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHARLES ST. BUITE 4105 BALTIMOREI MD 21204 RMAN DOBERMAN, MO

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

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32. Registrar's Sign

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State of Maryland / Department of Health and Mental Hygiene	2010	16129
Certificate of Dooth	L 0 : 0	

	1- For State Certificate of Death Reg. No.												
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Medical Exam	iner	ner ALFRED L. HASCEK May 9, 2010											
		4a. Facility Name (if not institution	n, give street and num	iber)	4	b. City, Town, or I	Location of De	ath	4c. County of Death				
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Z. p e a s	10	19a. Informant's Name/Relations			19b. Mailing	Address (Street	and Number o	or Rural Route N	lumber,	City or Towr	n, State, Zip Code)		
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To the Hos within 24 b To the Fur completely	<u>S</u>	(Check only	/sician: To the best o niner:On the basis of e	r my knowledge, examination and	, death occurre /or investigatio	o at the time, date n, in my opinion, o	e and place, ar death occurred	nd due to the ca I at the time, da	use(s) ai te and pl	nd manner a ace, and du	e to the cause(s)		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** <u>Eleanor Mae Hood</u> May 6, 2010 2:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kline Hospice House
5. Social Security Number 6. Sex Mount Airy ear | If Under 24 Hrs. Frederick Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🗓 F Yrs Director 220-48-1718 84 17, 1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State traumatic event, the Medical Exprainer must be notified at 1 ☐ Yes 2 X No Director Maryland | Frederick 28a-f Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō or items 23a USA 601 Prospect Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) filed within n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Clyde Moxley Clytie Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau 200 Smithfield Drive, Middletown, Maryland 21769 <u>Darlene Clay</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Methodist Cem 5/10/2010 Mount Airy, Maryland 21. Signature of Funeral Servi Licensee 22. Name and Address of FacilityMolesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freair failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in de th) Physician phomo /Medical Due to (or as conse wence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician Box 68760. Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No for Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown þ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 X No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo has page 2 certificate Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Hospice 1∐Yes 2. XiNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CRNP, 1502 Rochelle Dyer, South Main Street, Suite 104, Mount Airy, Maryland ROCIIE 11-31. Date filed (Month, Day. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Maryland

12:18 PM

Year

Somerset

USA

Black, White, etc.

White

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Henry Hurley, Thomas May 4, 2010 8:39 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 30533 Creekview Drive Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F 63 213-44-0834 Director 12-28-1946 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30533 Creekview Drive 21853 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. No Pyes 2 No Pyes, Give Year or Dates:1974-76 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Medic Come. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Henry Hurley, Sr. Mary Rosetta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30559 Creekview Drive, Princess Anne, MD 21853 Jamie Torres/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/06/2010 Salisbury, Maryland Salisbury Crematory Signature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 Ba. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causeyon each line. Immediate Cause (Final **Physician** disease or condition resulting in death) min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 d Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 2 No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After (Month, Day Year) To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: 🎜 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print)
Brett Hoffman M.D. 30434 Mt. Vernon Road, Princess 30. Name and address Anne, MD 21853 31. Date filed (Month, Day, Year) NAY 10 2010 32. Fegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20<u>10</u> 5:38 PM MAY BARRY JACKSON Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 3734 DUNLAP STREET TEMPLE HILLS Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours Min. ILLINOIS Director 351-40-6898 Ĩ948 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No TEMPLE HILLS PRINCE GEORGE'S MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3734 DUNLAP STREET USA items 2 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Xyes 2 No MARINES
If Yes, Give Black, White, etc. õ Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK "naturaf", Specify: 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene, is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH MAINTENANCE SUPERVISOR Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILLIE JACKSON NELLIE HARWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELODY JACKSON/DAUGHTER 4110 FARMER PLACE FORT WASHINGTON, MARYLAND 20744 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation_5 ☐ Other (Specify) VETERANS CEMETERY 5/10/2010 CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death a Hysician/ disease or condition ADENOCARCINOMA OF DHODENIM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv death? certificate 1 ☐ Yes 2 🛣 No 2 XNC Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🙀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after decral Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26250 MAY 7, 2010

State Registrar MATILDA H. SO M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year) MAY 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lawrence Lowell Johnson 10:00 P May 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12512 Arrow Park Drive Fort Washington Prince Georges 8. Date of Birth (Month, Day, Year) Oct. 12, 1920 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 X M 2 □ F Virginia 89 224-16-7838 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2X No Director MD Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a must 12512 Arrow Park Drive 20744 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Examiner 1 Yes 2 □ No If Yes, Give 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify. Specify: Year or Dates: 1942 -46 þ 3 X Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Civilian Engineer U. S. Government 5+ permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathaniel Johnson Arie Mariah Perriel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arie J. Gray - Daughter 12512 Arrow Park Drive, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenaham Veterans 5/17/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L K. Johnson Funeral Home, P. A e., Temple Hills, MD 20748 6503 Old Branch Ave., Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** years Find Stage Dementia Due to (or as consequence of): /Medical Examiner years Advanced Parkinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit Failure to Thrive years and Due to (or as a consequence of): Box 68760, the attending physician Seizures years Physician/Medical as the b IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by G-tube, pacemakers, Immobility Syndrome 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Deep venous thrombosis right page 2 s autopsy performed? this certificate 1∐ Yes 2No Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar

Allen Reilly, MD 31. Date filed (Month, Day, MAY 1 1 2010

29b. Signature and the

12304 Baltimore Blvd, Beltsville, MD 20705 32. Registrar's Signature

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

29c. License number

D54749

29d. Date signed (Month, Day, Year)

May 10, 2010

DHMH 17 Rev 1/2001

State Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend #17 perfuneral home 5/10/1 @ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month May Physician/ Maria 6^{Day} 2010^{Year} Franczika Kelly 3:50 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Pineview Future Care Clinton Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TX Months Hours Min. Czechoslavakia 82 1924 80 Director Feb 4 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 🏋 No Prince George's Maryland 1 4 1 Forestville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 7805 Sunny Lane 20747 United States items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Force Black, White, etc. ō 1 Never Married 2 Married 1 Yes 2XX No If Yes, Give Year or Dates. ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: Completed White and Mental Hygiene.

I is marked other than "naturraumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Cook Restuarant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked ony injury or other traumatic eve ည Unzeitig Johann Unzeitie Christine Pelz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bell (Daughter) 7805 Sunny Lane, Forestville, MD 20747 Method of Disposition

★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery May 12, 2010 Cheltenham, Maryland 22. Name and Address of Facilities Fineral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 any in 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ned for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Yes 2 the 9 Unknown Unknown sate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes Other: Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I lursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral to Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 1 🗌 Yes Investigation Could not be 2 🗆 No 3 ☐ Sulcide 4 ☐ Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Labanowski William May 4, 9:10 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Accokeek 1500 Airport Road Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 XXM 2 □ F Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 508 16 7132 Months Days Hours Min. Month, Day Year) Feb 4, 1922 Nebraska 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Prince George's Accokeek Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20609 1500 Airport Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces' 1 V Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 \(\text{Yes} \) 2 \(\text{No} \) No Specify: Specify: White 3 🕅 Widowed 4 🗌 Divorced Year or Dates. WII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Mills James Labanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1748 N. Cappero Drive, St. Augustine, Florida 32092 Charles Labanowski 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth May 8.2010 St. Mary Catholic Church Cemetery 1XX Burial 2 🗌 Cremation 3 🗍 Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Simatur uneral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 01 Ferry Road, Clinton, MD 20735 Part 1. Errer the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate cause (Final) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician SOU disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy performed this certificate | 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t 1 Natural 5 Pending sa er death. 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29c. License number lauese 63 1) 0056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6620 CRAIN HWY , STE 102. LAPLATA 2064-6 KARAKSITI 1541 K.D BAIG 31. Date filed (Month, Day, 32 Registrar's Signatur State 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 Charles Edward Lockard, Sr. May 6 07:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Conowingo Ceci1 175 McCauley Road 9. Birthplace (State or Foreign County) k Neck Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 222-07-4663 88 May 17,1921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Marylan 10a State 10b County 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Conowingo Cecil 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 175 McCauley Road 21918 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐ No IfYes, Give Year or Dates: 1942~45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: White 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Federal Elementary/Secondary (0-12) College (1-4or 5+) 8 Government <u>Maintenance</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ William Lockard Mary Pearce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 McCauley Road, Conowingo, Maryland Carol Vaccarini / Daughter 20b. Place of Disposition (Name of North East United 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of permit. Pages
Department of
Important: If it
any Injury or o XXBurial 2 ☐ Cremation 3 Removal from 8t May 13, 4 Donation 5 ☐ Other (Specify) Methodist Cemetery 2010 North East, Maryland 21. Signatur Funeral 22. Name and Address of Facility envice Lic Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Pair1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician unknown disease or condition resulting in death) oronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 1 TYPS 2 No. been signed by the should be detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performe 2 X No 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Division 1 Natural 5 Pending after death.

I Director: Af din by the fun 1 □Yes 2 □No investigation 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, ar title of certifier

10 +IVA

State Registrar Dria

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		Sta	ite of l	viaryian		rtment tificate					Reg. No.	010	16	139
		. Decedent's Name (First,	Middle, I									2. Date of De Month	Day	Year	3. Time o	of Death
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Examine	er 4	a. Facility Name (If not ins						4b. City, 1		Location ield				Somers		
	_	Alice Byrd T		Nurs . Sex		Age (In yrs.	last birthdav)	If Under				8. Date of Bir	th		hplace (State	or Foreign
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Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		19a. Informant's Name/Re	elationshi	p (Type. Pi	rint)		19b. Maili	ng Address	(Street a	and Num	ber or Hui — M =	al Route Num	er, City or -ati⊙r	nown, State, . MD	21838	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Edward Mattingly 25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 515 Greenway Avenue Cumberland Allegany . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 🗆 🕍 2 🗆 F Months Hours Jan 22 213-12-9187 Director MD 93 Usual Residence of Decedent or 28a-f shov notified at show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 ☐ **X**es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 515 Greenway Avenue 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 🗌 No 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates WW II Specify: Completed 3 - Widowed 4 - Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than "
r traumatic event, the Mec College (1-4 or 5+) owner J.I. Mattingly & Bros. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Joseph I. Mattingly Ellen (Ready) Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 515 Greenway Avenue Cumberland MI Mary Mattingly wife MD 21502 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 s 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State SS Peter and Paul Cemetery 5/20/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re Funeral Ser 19-11 22. Name and Scarpelif Fullyeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician anon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Year 1 ☐ Yes 2 ☐ Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗀 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. an title of certifie 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

e of death (Item 23a) (Type, Print)

and address of person who completed

31. Date filed (Month, Day, Year

Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

egistrar's Signature

072010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deat **Physician** MARGE SALVATONE 6 201C /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Day, Year)
Country
Marcus Hook
11, 1943 Pennsylvania 1 XM 2 ☐ F Months Days Hours 67 **Director** 222-26-6648 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Mcdical Examination be notified at 1 ☐ Yes 2 No Director Perryville Maryland Ceci1 10g. Citizen of What Country? 10e. Street and Number by Funeral 11 Cherry Lane 21903 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Affiled Follows:
1 Tyes 2 No
If Yes, Give
Year or Dates: US Army within 72 hours after 1 ☐ Never Married 2 ☐ Married 5-0036 1 □Yes 2 → No Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Construction Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in the form of Health and Mental 2 Roy A. Marge Clementine Barbone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai Sam Marge / Son 1309 Willow Chase Drive, Bel Air, Maryland 21015 Baltimore, 20b. Place of Disposition (Name of Cemetery, crematory or other place)
North East United
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Depurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) May 12,2010North East, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARDIOPULMONAM 11/WAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list currentials, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit ATHENOSC attending physician and for use as the burial-trar 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an certificate has autopsy perforn 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

10 +1 VA

BALRY W.
31. Date filed (Month, Day,

on who completed cause of death (Item 23a) (Type, Print)

WOHL M.D.

D22097

555 ALLIANCE ST. HAURE DE GRAVE, MARYLAND 21078

MAY 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames C Musun		1- For State Registrar	tate of Mary		artment of ertificate of		and Me	ental Hy		eg. No. 20	1() 1614		
Physici Medical Exami	an/	1. Decedent's Name (First, Midd		Musumo	o i				2. Date of Deat Month	Day Year		3. Time of Death 1645 hrs		
neulcal Exami	1161	James Craven 4a. Facility Name (if not institution				4b. City, Tow	n, or Locatio	n of Death	May 13, 20	4c. County o	f Death			
		Frederick Memorial H	lospital			Frederic	k		Frederick					
Funeral Director		5. Social Security Number 578-08-5056	6. Sex	7. Age (In yrs.	•		Year If Ur Days Hou	nder 24Hrs. urs Min.	1	h(MM/DD/YYYY) /1972	Foreign	hplace (State or Washington ^{untry)} D.C.		
ny		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Locati	on						10d. Inside City Limits		
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Maryland 28a-f show any 1 at once.	Director	10e. Street and Number				10f. Zip Co	de		10	g. Citizen of Wha	at Coun	try?		
th the ? 23a or notifie		801 Highland S					21701			United				
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	larried Armed	Decedent Ever in the Forces?		s Decedent o es, specify C			ecify Yes or No- Rican, etc.)					
ifter de 11", or	by Fu	3 Widowed 4 Div	1 Ye vorced If Yes, Give or Dates:		1	Yes 2X	No speci	fy:		Specify:	Wh	nite		
2 hours a "natura Examir		15. Decedent's Education (Spe	cify only highest g		16a. Deceden during me	t's Usual Occ ost of working				16b. Kind of Bus	iness/In	idustry		
36 hin 72 te. than "	Completed	Elementary/Secondary (0-12)	College	e (1-4 or 5+) 1	Tax	i Driv	/er			Trans	spor	tation		
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medisal Examiner	S	17. Father's Name (First, Middle					18. Moth			faiden Surname)				
121 Id be fi fental I narked event,	Be	Joseph B. Musu:			10h Mailine	Addross (S			ron Cra	ven	Chala	Zi- Code)		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	٩	Joseph Musumec		her		· ·				\sim MD 217		Zip Code)		
re, N s 1 and f Health if item er trau		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Remova		Place of Disposi crematory or oth		of cemetery,	May	Date 18.	20c. Location - 6	City or T	ſown, State		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	pecify:	Re	sthaven			20	010			, Maryland		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Plygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Six e of Fune II Service	, MD	ly P.A. 21701										
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876(tificate ng phy as the b	>	IF FEMALE: 23b. Was decedent pregnant in t	200, 11 90	s, outcome of pre e birth	gridinoy	al death		pic pregnan	су	23d. Date of d Month	lelivery Da	ay Year		
Ox 6876 eath certificate s attending phy for use as the l	S	past 12 months? 1 Yes 2 No 9 Un	lenous .	egnant at time of d known	onth	ner (Specify)								
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F, P.C ires that signed l	d by								1 Yes	2 No 3	Proba	ably 4 🗸 Unknown		
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tal Reco cian: The law certificate has	Completed			· · · · · · · · · · · · · · · · · · ·					perform 1 Yes 2		ath? Yes	2 No		
Vital Rec ysician: The l his certificate l director, page	å	25. Was case referred to medica examiner?		Inpatient 2	ER/Outpatient		lace of Deat Other		nly one) Home 5 7	Residence 6	Other:			
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ion ttendir leath. tor: A	atio	1 Natural 5 Pen 2 Accident	dirig ctigation	nin, Day, reary		1[Yes 2	No						
Divisior pital or Attend ours after death leral Director: filled in by the	ertification:	3 Suicide 6 Cou	Id not be rmined (Speci	lace of Inju ry - At h fy)	nome, farm, stree	t, factory, offi	ce building,	etc. 2	ef. Location (S or Town, St		or Rura	al Route Number, City		
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	dical C	29a Certifier	hysician: To the biminer: On the bas and manner	is of examination										
5 7 × 5	Medi	29b Signature and title of certific		Jacou.		- 1	ense numbe	er		29d. Date signed	(Mont	h, Day,Year)		
		(huest 2				0	.C.M.E.			May 14, 201	0			
2		30. Name and address of person Ana Rubio MD. Ass	n who completed ca sistant Medica		^{n 23a)} 111 Penn S	treet, Balt	imore, Mi	D 21201						
う S	ate	31. Date filed (Month, Day, Year)		Registrar's Signat	ture .									
Regis		MAT I	7 711111	10 135300 1	B. Sol	Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Of State of Registrar	913,3376272 Ce	artment of Hortificate of D	ealth and eath	Mental H	ygiene	nin	5 44
			Decedent's Name (First, Middle, Last)	- Cutii	2. Date of D		010	3. Time of Death		
	Physicia Medic		Lorraine Eliz	abeth Matt			Month Apr	Day 11 14.	2010	6:55 P M
	Examir		4a. Facility Name (if not institution, give street and number		4b. City, Town, or L	ocation of Dea			unty of Death	
40.0	<i></i>		Frederick Memorial Ho		Fred	erick		l I	ck	
	Funeral Director		1 M 2 F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth av. Year)	9. Birth	place (State or Foreign
			Usual Residence of Decedent	90 Yrs.			Feb 9	1920	Mi	chigan
	and show	ō	10a. State 10b. County	10c. City, Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Frederick		Frede	rick				1 ☐ Yes 2x ☐ No
	a or s		10e. Street and Number		10f. Zip Code	LICK		10g. Citizen	of What Cou	ntry?
	h with	Funeral	5955 Quinn Orchard Road		217	04		Uni	ted St	ates
	riten Inerr		11. Marital Status 12. Was Deceden Armed Forces	?	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (S Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14.	Race - Americ	can Indian,
36	al", o	d by	1 Never Married 2 X Married 1 Yes 2 If Yes, 3 Widowed 4 Divorced Yes, Sive	X No	I ☐ Yes 2 🛣 No				Black, White, cify: Whi	
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Education		dent's Usual Occupati	ion				
215	n 72 e. ian "r Med	m	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	(Give	kind of work done dui O NOT use retired)		orking	166. Kind o	of Business In	dustry
2	withi		12	· ·	Homemaker			Own	n Home	
nd	filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Na	me (First, Middle	, Maiden Surn	ame)	
₹	uld be I Men narke natic	_	Frederick Perlberg			The	resa So	raruf		
Maryland 21215-0036	d 2 should be 1 alth and Menta 127 is marked ir traumatic e		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and					Code)
	and and Healt		Joseph Matt III / Son		38 Indigo	Lane, I				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from Stat		natory or other place)	:	Date	20c. Locati	on - City or To	own, State
≢	nit. P.		4 Donation 5 Other (Specify) 21. Signature of June all Service Licensee	Stauffer	Crematory Name and Address	4/	19/10	Frede	rick, l	Maryland
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П			23a. Part 1. Enter the disease or complications that cause	ed the death. Do not ente	r the mode of dying,	such as cardia	or respiratory a	ederick rest,	c, MD	Approximate
4	chysician/		shock, or heart failure. List only one cause on each li							Interval Between Onset and Death
	Medical			ation Pneumo s a consequence of):	mia				-	
	Examiner	_	Sequentially list conditions, b. Conges	stive Heart	Failure					
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	and and trans	xan	Cause (Disease or iinjury that initiated events c.							
_	oe exe	ial E	resulting in death) Last Due to (or as	s a consequence of):						
760		edical	d							
89	certifi nding use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					20.1	D-1: (1 !!	
Box 68	eath a for	icia	in the past 12 months? 1 ☐ Live Birth 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant		Ectopic pregnancy Other (specify)				Date of delive Month	Day Year
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о. О	law requires that the ras been signed by the 2 should be detach	by P	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given	in Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
ds,	quires en sig	ed	Diabetes Mellitus				1 🗆	Yes 2 XIN	o 3 🗆 Prob	pably 4 🗆 Unknown
Vital Records,	aw red	ple					24a. Was		b. Were autop	sy findings available
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10 0	ding F	Certificate:	27. Manner of Death 1 Natural ury 28b. Time of injury	28c. Injury at work?	_	28d. Describe h	ow injury occi	urred		
0	deati deati stor: / the	<u></u>	2 Accident Investigation 3 Suicide 6 Could not be			s 2 🔀 No				
DIVISION	after after Direct	Š	4 LI Homicide determined 28e. Place of In building, et	jury - At home, farm, stre tc. <i>(Specify)</i>	ет, тастоту, описе		28f. Location (S City or Tow		nber or Rural	Route Number,
_	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier 1 **Certifying Physician: To the best of	f my knowledge, death or	cured at the time. da	ate and place	nd due to the car	ise(s) and ma	nner as state	
	he Ho in 24 he Fu plete	Med Med	(Check 2 Medical Examiner: On the basis of e	examination and/or investi	nation, in my opinion (death occurred	at the time date a	nd place and	due to the cou	co(c) and manner stated
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		[30. Name and address of person who completed cause of o		int)			-, -, 1/		
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	State Registra	4	APR 19 20 0 32. Regist	ar's Signature	back					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:40PM 09 MA Judith I. Mevers 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE None HOSFI AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Hours Months Days Min. 1 □ M 2 🔀 F 65 10/11/1944 Director 212-44-2568 MD Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, It a Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 United States 1214 Maple Crest Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Secretary Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Grisso Elizabeth Chaney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun Ronald L. Meyers - husband 1214 Maple Crest Drive Westminster, MD_ 21157 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/14/2010 Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemetery 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature Funeral Service Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 a + 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin and Due to (or as a consequence of) burial-t physician at the burial Division of Vital Records, P.O. Box 68760 Physician/Medical asi the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 4 Pregnant at time of death 5 ☐ Other (specify) detached cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 √Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No MEYERS. or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending To the Hospitar or within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09 - 2010 Kohit Jain -21799 MA

State Registrar

DHMH 17 Rev 1/2001

Tann

AUE

parked

CATON

32. Registrar's Signature

BALTI MORE

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

JAIN

ROHIT 31. Date filed (Month. 900

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 9 PM MAY abeth 10 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1-23- Birthplace (State or Foreign Country) **Funeral** Min. Months Davs Hours 1 M 2 7 219-44-4438 73 Clear Spring, MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified MDWashington Williamsport 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or Honeyfield Rd 21795 U.S.A. 10602 : If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must to 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 1 No Specify: White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged) 15. Decedent's Education (Specify only highest grade completed) board Elementary/Secondary (0-12) College (1-4or 5+) Food Service Hsst 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lilliam Grove Sr. dna Mason ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10602 Honeyfield Pd Williamsport MD 21795 19a. Informant's Name/Relationship (Type. Print) daughter Barbara Hilda bran 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 114 Department or Important: If i any injury or once, 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Hagerstown, MD edarLawn Cemeter 4 ☐ Donation 5 ☐ Other (Specify) Thompsen Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE CHOLESTATIC JAUNDICE WITH LIVER PAILURE WEEKS disease or condition resulting in death) /Medical **Examiner** MALIGNANT ASCITES WITH ADENOCARCINOMA UNKNOWN PRIMARY WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknowr 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ON CHRONIC RENAL FAILURE ON HEMODIAYSIS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 5 29b. Signature an title of certifier Dool 2895 MAU 2010 1500 Pennsylvania Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DALEY

PAULINE

RICHARI) S

32. Registrar's Signature

2. Registrar's Signature

HAgerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 8:10A May 07, Nancy Elizabeth Moody 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico 608 Dawn Court Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1 M 2 F Months Days Hours 217-28-4394 76 9/15/1933 GA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 608 Dawn Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) John B. Parsons Home Head Chef 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dock Noah Chandler Corine Battle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5909 Butterfield Drive - Clinton, MD 20735 Diane Chandler Banks/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1XI Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fastern Shore VA Cemetery May 14, 2010 Hurlock, MD 22. Name and Address of Facility Salisbury, Maryland 21. Signature of Funeral Service Licens Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multble Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the caping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3☐ Probably 4☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home

Physician /Medical Examiner

executed

Hospital or Attending Physician: The law requires that the death certificate be

Box 68760,

P.O.

Division of Vital Records,

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be

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MD

, and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it a lifedical Examinatinate to notified at

death with the Maryland

within 72 hours after

Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

3altimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical

and burial-tran physician the attending 0 the ģ has page 2 certificate

þ Completed Be Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the To the within 2 3m Registrar

After

death.

1 ☐ Yes 2 ☑ No 27. Manner of Death 1. Natural 5 Pending investigation 2 Accident 3 Suicide 4 🗌 Homicide

6 □Could not be

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

nd address of person who completed cause of death (Item 23a) (Type, Print)

10: v. vim 14, 164 1/2, nd 2180x

5/10/10 D0052-674

5 Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name 146

Nonth, Day, Year MAY 10 1746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year SAMUEL MARCH, JR. May 8:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 5 9. Birthplace (State or Foreign **Funeral** 1 K M 2 🗆 F Months Days Hours 1932 South Carolina **Director** 579-38-4741 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 Funeral 1421 34th Street, SE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 🔀 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black "natural", 1 ☐ Yes 2 🕱 No Specify: 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel March Louise Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. March - Wife 1421 34th Street, SE, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/08/2010 |Beltsville, Maryland 21. Signature of F 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 4531M disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signated by page 2 should by Completed 1 ☐ Yes 2 DNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, 0 5104110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR-10 32. Registra 's Signa

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bettie C. Milasuk 1:15 A^M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6810 Forbes Blvd. Lanham Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) August 31, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F 511-18-4403 Director 92 Mulvane, Kansas Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 28a-f Prince George's Lanham 1 X Yes 2 No Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20706 6810 Forbes Blvd. USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Gi 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government 4+ Transportation Industry Analyst event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ರ Page 1 and 2 should be Theodore C. Conklin Janie Rucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 7 Gregoria Court, Baltimore, MD 21212 Nancy J. Downs / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 5/10/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Comy RAY Rogers Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No ğ Month Year 5 Other (specify) been signed by the a should be detached Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has page 2 autopsy performed' 1 🗆 Yes 2 🗆 No Yes 2 X No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) injury 5 Pending Accident work? 1 Yes 2 No death. Investigation after death Director: / the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined e Funeral I Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi

DR 10

State Registrar

(Check only one 29b. Signature a

d title of

ertifie

Jacðb Cherian, 10910 Little Patuxent Parkway, Suite #105R, Columbia, MD 21044 31. Date filed (Month, Day, Year) **WAY 1 1 2010** 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6, 2010 Physician/ Maxwell. Mary 7:39 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2403 Fairlawn Street Temple Hills Prince George's Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 231 36 7687 1 □ M 2XX F Hours Jan 23 Day Year 88 Director Beligum Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director пs 23a or 28a-f s must be notified Maryland Prince George's Temple Hills 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2403 Fairlawn Street United States 20748 items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-14. Race - American Indian, Armed Force Yes, specity Cuban, Mexican, Puerto Rican, etc. Rlack. White, etc 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify Specify: White "natural", 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Animal Warden P.G. County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Franz Hellemans Maria Eskens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Long (Daughter) 2403 Fairlawn Street, Temple Hills, MD 20748 20a. Method of Disposition
1 ☐ Burial 2 Arcremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lee Crematory May 8, 2010 Clinton, Maryland 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Suvice Line, 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician nronic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Il any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE After this certificate has been signed by the attendin funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24 hours after death.
Funeral Director: After this certificate has been eted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Yo Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29c. License number D0052999 aluman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSpital Drive G-06 CLINTON 20735 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis Alexander Novinski 10:30 P ^M May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 314 Benfield Road Severna Park Anne Arundel 7. Age (In yrs. last birthday) cial Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-56-8308 1 X M 2 🗆 F Months Hours 167974350 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Severna Park Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 314 Benfield Road 21146 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Coil Winder Westinghouse permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any Injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Novinski Hazel Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $730\ Mills\ Way,\ Annapolis,\ MD\ 21401$ 19a. Informant's Name/Relationship (Type, Print) Anne Small- Friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/6/2010 Baltimore Crematory Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Myelin Tilloler 147 Duke of Gloucester St, Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed ywithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfor death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 92 W. Washington Street Annapolis, MD Brenda Mathews-Vitello 32. Registrar's Signature 31. Date filed (Month State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Pamela Sue Nottingham ,33AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbur Wicomico α + Hospice Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Months Days Hours Min 53 **Director** 220-66-4044 Yrs 10/21/1956 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Salisbury 1 Tes 2 X No Maryland Wicomico ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be i Funeral USA 606 Barnsdale Drive 21804 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Social Elementary/Seconday (0-12) College (1-4 or 5+) Services Family Investment Supv. Be other traumatic event, it. Page 1 and 2 should be filed vartment of Health and Mental Hygertant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Gilmer Nottingham Doris Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Hayes Ave., Salisbury, Maryland 21804 Pat Pryor POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bates Memorial 20c. Location - City or Town, State Date ò 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State artment ☐ Donation 5 ☐ Other (Specify) 05|10|2010|Snow Hill, Maryland Cemeter 22. Name and Ad Holloway ress of Facility
Funeral Home P.A. 94 0 Snow Hill Rd., Salisbury, Maryland 21804 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ MRTASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mooths?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year Day the Unknown 9 Unknown as been signed by a 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe certificate Yes 2 1 🗌 Yes 25. Was case referred to medical examiner? Be B 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Director, / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 21802 BOK WAN gistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Μ. OSTRI 5/6/2010 11:05aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 100 Severn Ave. #302 Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🗹 Months Days Hours Min. (M87/77/1920 MD try) 218-09-2153 89 Director Yrs Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes XX No Annapolis 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 100 Severn Ave. #302 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2xx No If Yes, Give 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Banking Be Department of Health and Mental Himportant: If iten 27 is marked oth any injury or other traumative oppose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Issak Setzer Rosa Milamed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Ostrusky 112 Carville Ct. Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Kneseth Israel Cem 5/7/2010 4 Donation 5 Other (Specify) Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signatu e of Funeral Service Licer Ridgely Ave. Annapolis, MD 21401 23a / P / 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. L'st only one cause y each line. Approximate Interval Between Imr diate Cause (Final dis se or condition resulting in death) HRTERIOSC Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown be detached significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nceR 1 Yes 2 No 3 Probably 4 Unknown heumatica 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsv performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 📈No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 U Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death.

eral Director: After this certificate filled in by the funeral director, pag within 24 hours a

To the Funeral D

completed filled i Hospital To the 4 0 0

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

been:

has

determined

30. Name and address of person who completed cause of death (Item 23a) (Typ H. KRIEGER

72 hours after

Maryland 21215-0036

Baltimore,

DHMH 17 Rev 7/2009

State

Registrar

istrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 8, 2810 11:50 PM John Paul Operchuck Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6100 Quebec Place Berwyn Heights Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov 8, 1931 1 X M 2 🗆 F Months Days Hours Min. West Virginia **Director** 232-48-0441 78 Usual Residence of Decedent shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director · 28a-f 1 Yes 2 X No Maryland | Berwyn Heights Prince George's ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20740 United States 6100 Ouebec Place filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 X Married Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 'natural", 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail/Lumber Sales other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file treent of Health and Mental tant: If item 27 is marked o ပ Daniel Operchuck Margaret Light 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita M. Operchuck/wife 6100 Quebec Place Berwyn Heights, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) cemetery, crematory or other place) Final Journey Crematory 5/12/2010 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 21. Sig ure of Funeral Service Licen M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician, COPD disease or condition 10_years Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Ischemic Cardiomyopathy 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law this certificate has performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to be in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pendina 1 🗌 Yes 2 🗌 No Investigation 6 Could not be To the Hospital or Att within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. прleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47654 May 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 841 Charlotte Dean, M.D. 110 Irving Street, NW Washington, DC 20010

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month Par Year 1 2010

32. Fegistrar's Signature

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAOLD EUZABETH (2-28 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>7311 Sara Street</u> New Carrollton

der 1 Year | If Under 24 Hrs. | <u>Prince George's</u> Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year 3 - 2 8 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖭 Months Days Min. Year) California Director Yrs 545-14-6376 89 192 Usual Residence of Decedent show 10a. State 10b. County äŧ 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified a 1 Yes 2 XNo Maryland Prince George's New Carrollton 10e. Street and Number ò ems 23a or 10g. Citizen of What Country? Funeral 7311 Sara Street 20784 United States r than "natural", or items the Medical Examiner mu filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist Doctors Office Be Department of Health and Mental H
Important If Item Z7 is marked oth
any injury or other traumatic once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bercie Barnett Barnwell Ella Mary Cotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Agee/executrix 8502 Paxton Court Berwyn Heights, Maryland 20740 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/11/2010 Woodbine, Maryland 21. Si while of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition resulting in death) weeus Medical Due to (or as a consequence of) Examiner ronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death Month Day the 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ∠ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performed? Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 X-No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident 3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

12

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32. Registrar's Signature

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tr. top

phanie

D37934

7500 Greenway Center Drive Greenbelt MO 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 May 4:15 P Medical Ryan Joseph Parker 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Carroll Westminster 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F Months Min Director Yrs 214-24-4713 1928 Maryland Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No Maryland Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 14580 Triadelphia Mill Road 21036 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö β 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: "natural" Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nuclear Physicist Federal Government 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Constantine Parker Rosie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1539 Wakefield Valley Road New Windsor, MD 21776 Mari Parker/daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 5/11/2010 Woodbine, Maryland 21. Signat of Funeral Service Licer Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Bever. 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Priysician/ Medical Due to (our s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atter page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🖈 No Other:)0 VT မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Dending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License numbe 29d. Date:

Registrar
DHMH 17 Rev 7/2009

State

Flavio K 31. Date filed (Month) Par Center

South

Registrar's Signature

Street Westminster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ALTON ROWLES RICHARD 05 2010 2:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine 1008 WEIRES AVENUE LAVALE ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M M 2 □ F Director 81 198-20-8630 06/14/1928 Pennsylvania 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 □Yes 2√2 No ALLEGANY LAVALE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1008 WEIRES AVENUE 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PA STATE HWY ADMIN DISTRICT ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALTON DOUGHMAN ROWLES ပ DORIS (MacGUFFIE) ROWLES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. MARY LOU ROWLES - wife 1997 WEIRES AVENUE, LAVALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/10 CRESAPTOWN, MD Crematery fes of Facility Signature of Funeral Service Licensee HAFER FUNERAL SERVICE, P.A. ohn 1302 NATIONAL HWY., LAVALE, MD 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on paer line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 466,00 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∏Ho Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No

Physician: The law requires that the death certificate be executed Box 68760,2 attending physician P.O. the Division of Vital Records, been has certificate this After

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State Registrar

Medical

6 Could not be

determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month George Vivian Robey May 16, 2010 5:43 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Homewood at Crumland Farms Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/17/1923 9. Birthplace (State or Foreign Days Months Hours Min 11 M 2□F 87 578-09-8174 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2☐No Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2533 Parks Mill Road 21710 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Gov't/ Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>finance officer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vivian Robey Virginia Caywood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Robey / daughter 645 Lakeland Rd., South, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 5/18/2010 | Smithsburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home ender lire MO1222 106 E. Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pa Imary bst 14ct 12e chronic 0 2042 Due to (or as a consequence of) Sequentially list conditions, if any, bearing to infine-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? E. brillation 1 ■Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation

Physician /Medical Examiner Examiner

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permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental hygiene. Important: If Item 27 is marked other than 'natu any injury or other traumatic event, the Medical

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

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Funeral Director

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Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Physician/Medical Completed by Be Medical Certification: To

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

6 Could not be determined

within 24

State Registrar 29b. Signature and title of certifier

29c. License number 27122 T

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) May 17,2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) 9093 Ridge Field DA # 104 FREDERICK, Nd. 21701

32. Registrar's signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici tely filled in by the funeral director, page 2 should be detached for use as the buri	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of preg		al death	3 Ector	pic pregnar	псу	Month		ay Year
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the ple	Medical	one) 2 Medical Exami	ner:On the basis of exa	mination a	and/or investigat	on, in my op	inion, death	occurred at	the time, date	and place, and	due to the	e cause(s)
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	Sta Registr		31. Date filed (Month, Day, Year)	2010 32. Flo gistra	ar's Signa	D.	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month May 20 ľo 02:00 PM Marie Elizabeth Schwartz Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 10 Colonial Circle North East 8. Date of Birth (Month, Day, Oct. 9, 9. Birthplace (State or Foreign Country Chester Pennsy Ivania Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2**X** F Director 91 162-28-0016 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 Yes 2 No Delaware New Castle Wilmington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 19810 2608 Longwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2XXX No If Yes, Give 1 ☐ Yes 2XXX No Specify: White Specify. Completed 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie McCew Edward Gillespie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Colonial Circle, North East, Maryland 21901 Marie Roberts / Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 Cremation 3 4 Doparton 5 Other Specify 8,2010 Linwood, Pennsylvania Lawncroft Cemetery 22. Name and Address of Facility Crouch Funeral Home 21. Signa un 127 South Main Street, North East, Maryland21901 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' 2 🗆 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate funeral director, within 24 hours after death

To the Funeral Director, α
completed filled in by the To the l within 2 To the l

Certificate:

Medical

1 Natural

☐ Accident ☐ Suicide

4 Homicide

only one

Name and address

Dria Date filed (Month, Day, Year)

29b. Signature

29a. Certifier (Check

5 Pending

Investigation

6 Could not be

21215-0036

Maryland

Baltimore,

DHMH 17 Rev 7/2009

State Registrar

10

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1404M DIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** tagers town Washine If Under 1 Year | If Under 24 Hrs. 9. Birthplade (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 XM 2 □ F 18,1933 MD 217-30-5837 76 July Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- any injury or other traumatic everal. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2X No Director Martinsburg Berkeley 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25405 USA 510 Butler Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 X Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer National Park Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ellen Smith James R. Smith မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1337 Harvest Hill Lane Lancaster, TX 75146 Kim R. Smith/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 05/15/2010 Hancock, MD St.Peter Catholic 22. Name and Address of Facility 21. Signature of Fundral Service Licensee 141 West Main Street MOO260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inbutes Mellitu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to for as a consequence of Physician/Medical Examiner requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No certificate 1∐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A
ely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the ...
within 24 hours c...
To the Funeral Dirr Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-2+1 14014 Marsh EYle 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 13 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:50 FM Scott Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death SA CONSTAL COM HOSE 15 EAT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 257-12-498 Months Days Hours Min. (Month, Day, Year) 91 Director Usual Residence of Decedent 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Princess 1 Yes 2 No Somers Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral William 21853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married <u>6</u> If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 - Widowed 4 - Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) treight 12th grade ruck Be Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Avery Scott Moses Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Princess Anne, md 21853 Bivens Friend William eon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury, md -6-10 Salibury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony Ward F. H. 0639 Anne, Md 21853 Humpden Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a ARTHROSCLAROTIC disease or condition resulting in death) DISRASR CARDIOVASCULAR Medical Due to (or as a consequence of): Examiner Sequentially list conditions, day, Isabing to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy autope performe 2 NO 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA HOSPICA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🚜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 SKTY BUGGE Box State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** hoE hiE 0200 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisburg Rehabilitation + Nursina Cta 5. Social Security Almber 6. Sex 7. Age (In yrs. last birthday Wicomico If Under 1 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Months 1 ☐ M 2 🖾 F 96 1914 NORLA CAROLINE 168-16-3911 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 INo perrit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Madical Examiner must be notified. Wicemico Funeral Director PARSONSburg MARULAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 45A 33089 21840 CEAN 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2. No Specify þ 3. Widowed 4 □ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARlEI MARGARE Coston ပ 19b. Mailing Address (Street and Number or, Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mel 20785 - Niaca 5315 N. Engle Wood LANDOVER CLARA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 14-2010 GLASS 5-PARSONS DURG 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME 821 STEWARD md CINERAL 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final our. Physician estra. nanca disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Hospital or Attending Physician; After this certification, property of 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 1 hours after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide .∩ 24 hou. •• Funeral D •filler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig us (om 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200C William H. Robins, M.D.

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

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	Physicia Medic		ANGIE SMITH				May	5 Day 2010	9.50 AM
	Examin	er	4a. Facility Name (if not institution, give street and number) DOCTORS HOSPITAL		4b. City, Town, or LANHAM				GEORGE 'S
	Funeral Director		5. Social Security Number 238-64-9173 6. Sex 1 □ M 2 🛣 7. Age (In yi	rs. last birthday) 70 Yrs.	Months Days	If Under 24 Hrs Hours Min.		5 1939 NO	Birthplace (State or Foreign CAROLINA
	nd how at	۲	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation				10d. Inside City Limits
	Maryla 8a-f s	rect		MITCHELI	LVILLE				1 🛣 Yes 2 □ No
	ith the I	Funeral Director	10e. Street and Number CANTERBURY 11507 CANTERBURG COURT		10f. Zip Code	721		10g. Citizen of Wha	t Country?
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	and 2 sho Health and tem 27 is r		JAMES SMITH/HUSBAND	1150	7 CANTER	HIRG COUL	RT MITCHE	City or Town, State LLVILLE, N	e, Zip Code) MARYLAND 20721
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Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee		. Name and Addres	oo or r manney		KINS FUNI R,MARYLAI	
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. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 1 ☐ Pregnant at time 2 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	гу		23d. Date o Month	f delivery Day Year
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Division of Vital Records,	The law recate has been page 2 sho	Completed by					24a. Was a autop perfor 1 Yes	sy prio med? dea	e autopsy findings available r to completion of cause of th?] Yes 2 \(\text{No} \)
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			30. Name and address of person who completed cause of death (Item 23al (Time E		6012	0	5/6/	10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month ^{Day} 2010 **Physician** PIERRE LOYNNE SUMMERVILLE 12:23 P ^M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, DFC 2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Months Days Hours 1 M 2 F 577-74-6905 56 WASHINGTON, DC 1953 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 XYes 2 No MD PRINCE GEORGE'S FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11422 NORTH STAR DRIVE 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK ð 3 Wildowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) SUPERVISOR PRIVATE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin Important: if item 27 is marked - any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM ROLLINS LUCILLE SUMMERVILLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 19a. Informant's Name/Relationship (Type. Print) KAREN SUMMERVILLE/DGT 11422 NORTH STAR DRIVE FORT WASHINGTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State RESSURECTION CEMETERY5/11/2010 CLINTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licens 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 $K \cdot \mathcal{P}$. 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA ို 1 | Inpatient 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner the death certificate be executed attending physician and for use as the burial-trai Box 68760, the as o þ σ. signed by be deta Division or Vital Records, page certificate Physician: funeral director, this After or Attending

Funeral

Director

28a-f show

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23a

or items

"natural"

than

marked other

Physician

/Medical

filed within Hygiene.

the Medical Examiner must be notified at

within 72 hours after death with

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 36506

29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUNICE F. SHAKIR M.D. 6104 OLD BRANCH AVENUE TEMPLE HILLS, MARYLAND 20748

CA 10 State Registrar

n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu

Medical

Hospital

31. Date filed (Month, Day, MAY 1 1 2010

4 Homicide

(Check only one)

29a, Certifier



Physician	
/Medical	
Examiner	

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maritan Examinations be resilied at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

	Registrar	Cer	tificate of L	Jeath	F	Reg. No.					
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		V	3. Time of Death			
ian	EUGENE MARION THOMAS	III			Month MAY	Day 3	Year 2010	1736 [™]			
ical	4a. Facility Name (If not institution, give street and numbe		4b. City, Town, or	Location of Death	1	4c. County		1730			
ner	ANNE ARUNDEL MEDICAL CENTI		ANNAP				NE AR	UNDET.			
	5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign			
1	215-30-7542 1XM 2□ F	76 Yrs.	Months Days	Hours Min.	(Month, Day	5. 1934	MARY				
	Usual Residence of Decedent										
	10a. State 10b. County	10c. City, Town or Loc	cation				10	Od. Inside City Limits			
Director	MARYLAND QUEEN ANNE'S			CHESTER				1 □Yes 2 👿 No			
irec	10e. Street and Number	.1	10f. Zip Code	OHLDILIK		10g. Citizen of What Country?					
0	6007 BRIDGEPOINTE DRIVE		2	1619		UNITED STATES					
Funeral	11. Marital Status 12. Was Deceden	t Ever in U.S. 13. V	⊥ Vas Decedent of His Yes, specity Cubar	spanic Origin? (Sp	pecify Yes or No-	14. Ra	ce - Americ	an Indian,			
Ē	Armed Forces 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give	? II]No	_		Rican, etc.)	Bla	ck, White, e	tc.			
b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	1954–1956	□Yes 2 X No	Specify:		Specif	WHI'	TE			
ted	15. Decedent's Education	16a. Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness/Ind	lustry			
lg e	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life [kind of work done du OO NOT use retired)	uring most of work	ang	STATE					
Completed by	<u> </u>	· ·	L ANALYST			GOVERN	MENT				
Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surnar	ne)				
TO E	EUGENE M. THOMAS, JR			CATHERI	NE MCNE	LLIS					
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Numbe	er, City or Town	State, Zip	Code)			
١.,	DAWN M. THOMAS/WIFE	6007	BRIDGEPOI	NTE DETV	E. CHES'	TER MA	RYI.AN	D 21619			
	20a. Method of Disposition	20b. Place of Dispos	sition (Name of		Date	20c. Location					
	1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CREMATIO	natory`or other place SAPEAKE	FIAI							
	21. Signature of Funeral Service Licensee		N CENTER Name and Address	s of Facility	.0	STEVENS	VILLE,	, MARYLAND			
		_ FE	LLOWS, HE	LFENBEIN				HOME, P.A.			
	106 SHAMROCK ROAD, CHESTER, MARYLAND 21619										
	23a. Part1. Enter the diseast, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										
	Immediate Cause (Final disease or condition		Onset and Death								
	resulting in death) Due to (or a										
L	Sequentially list conditions b.										
ine	Sequentially list conditions, if any, leading to immediate cause. Tries underlying Cause (Disease or injury	s a consequence of):									
lam	that initiated events										
Ē	Due to (or a	s a consequence of):									
n/Medical Examiner	d										
Me	IF FEMALE:										
an/l	23b. Was decedent pregnant 23c. If yes, outcom		Ectopic pregnancy				te of delive				
Sici	1 Yes 2 No 4 Pregnant	at time of death 5	Other (specify)			Me	onth	Day Year			
Completed by Physicia	9 ☐ Unknown				1						
Ϋ́F	Part II. Other significant conditions contributing to death	but not resulting in the un	derlying cause giver	n in Part I.			tribute to th	e cause of death?			
pa	Colon Cancer				1 ⊠ Y	es 2□No	3 ☐ Prob	ably 4 ☐ Unknown			
je					24a. Was a	an 24b.	Were autor	osy findings available			
Ē					autop perfor	med?	death?	osy findings available npletion of cause of			
	25. Was case referred to medical			an Di			1 □ Yes	2 □ No			
Be	examiner? 1 Yes 2 No Hospital: 1 Inpa		Othor	26. Place of Deat							
Ë	27. Manner of Death 28a. Date of In		28c. Injury	4 Li Nursing Ho	ome 5 Resid)			
힐	1 Matural 5 ☐ Pending (Month, D	ay, Year) Injury	Work?	es 2 🗆 No	200. Describe II	ow injury occur	160				
ical	3 ☐ Suicide 6 ☐ Could not be 280 Place of Ir	njury - At home, farm, stre		es 2 🗆 140	Oof Leasting (O			(Davida Alivanta a			
불	4 ☐ Homicide determined building, €	etc. (Specify)	et, factory, office		28f. Location (S City or Tow	rreet and Numi n, State)	er or Hurai	Houte Number,			
ŏ	29a. Certifier 1 Certifying Physician: To the bes	t at man language along the									
ica	(Check only 2 Medical Examiner: On the basis	of examination and/or inv	actigation in my on	inion doath occur	rod at the time of	toto and place	and due to	the calleges			
Medical Certification: To	one) and manner s	nated.	29c Licence	number		20d Data signs	d (Month 1	Day Voar)			
-	Signal Bech	MO	7 C	16052	'	29d. Date signe	(is	Jay, Ital)			
	160)		,		J 1 /	110				
	29b. Signature and title of pertiner 29b. Signature and title of pertiner 30. Name and address of person who completed cause of Stuff Bluf, TWO 31. Date filed (Month, Day, Year) AV - 5 2010 June 1	death (Item 23a) (Type, F	rint) col De	asheray	Glast-	apolis.	no				
	of our local, too	July 1	THE PARTY OF THE P		10000	1, 1					
ate	31. Date filed (Month, Day, Year) 82. Regis	trar's Signature									
rar	min o cull conser	p. par									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7:53 P^M Marguerite Shirley Terwilliger /Medical May 6, 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Hills Assisted Living Dayton Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 ▼ F Director 097-22-0823 Aug 18, 1928 New York Usual Residence of Decedent f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐Yes 2 XNo Maryland 28a-f Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or death with 14269 Triadelphia Road 21036 United States Funeral items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married , or 1 □Yes 2 No Specify. Completed by Specify: 3 Widowed 4 Divorced 'natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse H. ပ Jones Elizabeth Decker 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Terwilliger Skrodzki/ 6120 Rippling Tides Terrace Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/11/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 thomas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on useh line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Physician/Medical Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 plonths? 1 □Yes 2 10 No Month Day Year 5 Other (specify) the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 □Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \subseteq Nursing Home 5 \subseteq Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 DOther (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗌 No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore.

after death Director: filled in by the 24 hours a within 2 To the

> 3 State

> > Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karla Sellers,

CRNP 6355 Ten Oaks Road, Suite 202 Clarksville, Maryland 21029 31. Date filed (Month 32. Registrar's Signature

WESTAM

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number R090290

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year tte Marie Wilson ann eMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the Salisbur icomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Florida 8. Date of Birth 1 □ M 2 🗓 F 214-46-4814 Months Days Hours Min. (Month, Day, Year) **Director** 62 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than """
any injury or other trans-10a. State 10c. City, Town or Location 10b. County Director 10d. Inside City Limits Dames Quarter 1 Yes 2 No Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10782 Rd U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 K No 1 Yes 2 No Specify: Completed 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry Industr 11th grade La borer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willie Wilson Ozella White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tull - husband Roberts 10782 Dames Quarter, md 21821 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗗 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 5-15-10 Dames Quarter, md Macedonia U.M.C. Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony Ward F. H. E. 30639 rden Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death ESOPHA GEAL MRTASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Seque thally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes ပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending injury work? 1 Yes 2 No Investigation Could not be Accident filled in by the within 24 hours after deat

To the Funeral Director:
completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28d per me, g905,0//15/2010dhb 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES 50 0609 M 1:mmoNS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TONINSULA REGIONAL SSUBBLE HICOMIGO 5. Social Security Number Year If Under 24 Hrs Age (In yrs. last birthday) g. Birthplace (State of Foreign 8. Date of Birth **Funeral** Months Days (Month, Day, Year) 1 M 2 - F Hours Min MARY LANC -78-2053 47 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Wilemiec MARYLAND SAlisbury 1 Yes 2 A No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral N. KOAd Cuelow 21801 USA. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1980 - \$2 1 Yes 2 No Specify. Specify: BIACK Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NONE LABORER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thment of Health and Mental rant. If item 27 is marked Immons SR Ellen Dashiell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dashiell limmons -Maher Road 21801 M)d permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 12-10 Me 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice yes 22 Name and Address of Facility Hell. TEWAR -UNERA! 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Multiple Traine Pilysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes completed filled in by the funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 | No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred
Passenger in auto —
auto collision work? 1 ☐ Yes 2 🗶 No 1 Natural 5 Pending injury 5/10 0300 2 Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 2 Willards Street Rt. 50 Willards manyland within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) H5049) 5/5/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 21801 tomer 100 Camal

State

Registrar

31. Date filed (Month, Day, Year)

MAY 10

Registrar's Signatur

10-03473

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Vanessa Timmons 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day May 5, 2010 0310 hrs Medical Examiner 1:mmons VANESSA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) US Rt. 50 East of Woodward Road Willards Wicomico If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours Min Director 49 Country) 217.74-0267 21-1961 1 M 2 F MARHIONN Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No tem 27 is marked other than "natural", or items 23a or 28a-fshow traumatic event, the Medical Examiner must be notified at once. Salisbury Willm: CO ID 21215-0036 3 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director DUCHUSEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA MOAd 533 CURLEW 2180 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? 1 Yes permit. Pages I and 2 should be filed within 12 nous area use Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner my Specify: BLACK If Yes, Give Year Yes 2 No specify: 3 Widowed 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specity only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NOVE emestic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) EVEN DAShiEll Charles Se Be immens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ na Ro limmons - Nother Daliebuen 533 CHRIEW 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State CEM 5-12-2010 4 Donation 5 Other Specify 21. Signature of Funeral Sery TEWAR FUNERA PALS Part I. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Discase or injury that initiated Due to (or as a consequence of) events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital ...
within 24 hours after death
To the Funeral Director: Af Driver auto auto collision May 5, 2010 0310 hrs 1 Natural Division 1 Yes 2 ✓ No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 3 ___ Suicide Could not be or Town, State) W/B US Rt. 50 east of Woodward Road, Willards, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6m

30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner

OCME

111 Penn Street, Baltimore, MD 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

May 6, 2010

32. Registrar's Signature State Registra

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **APR** Delores TATE Victoria 2010 1410 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner County General HOSD Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) ennsylvania 8. Date of Birth **Funeral** 1 M 2 X F Months Min. (Month, Day, Year) 8/5/1939 70 Director Yrs. 160-32-4880 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia 1 X Yes 2 No Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 US 10850 Green Mountain Circle #307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates. other than "natu ent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Bullock Victoria Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Phyllis Williams - Sister 11000 Lake Arbor Way Bowie, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Burial 2 X Cremation 3 Removal from State injury (Fort Lincoln Crematory 5/11/2010 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral rvi censee 22. Name and Address of Facility Fort Lincoln Funeral Home ances B401 Bladensburg Rd Brentwood, MD re, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the diger Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular disease or condition Medical resulting in death) Due to (or as a cons Examiner Hypertensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year ned by the at a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No Yes 2 N 1 Yes filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

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Charter Prive # 310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OIFOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registra Amend#27. PerPhys. PGC5-11-10cr Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05/02/2010 Year Russell Nathaniel Thomas, Sr. 17:03 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Washington Adventist Hospital</u> <u>Takoma Park</u> Montgomery If Under . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 130-34-5918 Months Days Hours Min 11/30/1945 64 Director DC Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 ☐ No Clinton Prince Georges 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 20735 9409 Silver Fox Turn AZU permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xyes 2 □ No If Yes, Give Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Safety Specialist Transportation other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 27 is marked or traumatic eve ပ Lemuel Thomas Anna Lee Lenoix Department of Health and M Important: If item 27 is man any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9409 Silver Fox Turn, Clinton, MD 20735 Pearl Thomas / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) incoln Memorial Cem. 05/06/2010 Suitland, MD Funeral Savige Licenses 21. Signature Strickland Funeral Services 6500 Allentown Rd - Camp Springs MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bhours Immediate Cause (Final Pulmonary Embolus Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 12 months Examiner <u>Deep Vein Thrombosis</u> Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal ucc. 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Yes 2 No detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Completed End Stage Renal Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2☐ ER/Outpatient 3☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of : After t 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) ending within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Seri Chutulli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHATRATH ; 7500 Hanover Packway; Swife 104; Granbelt, MD 20770

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mac Patricia Nan Trainum 2010 5:00 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 X F Hours Min. 220-38-4305 Director 69 September 10,1940 Washington. Usual Residence of Decedent show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits r 28a-f sl notified Prince George's Riverdale Maryland 1 X Yes 2 ☐ No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6109 54th Avenue 20737 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married 72 hours after Yes 2 X No 5-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7/ Health and Mental Hygiene. em 27 is marked other than Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Kissenger Bertha L. Kissenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aubry M. Trainum / Husband 6109 54th Avenue, Riverdale, MD 20737 permit. Page 1 and 2 Department of Health Important; If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 5/10/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service License 22. Name and Address of Facility 4379 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ COUTIS disease or condition ISCHETIC) Medical resulting in death) Due to (or as a consequence of): Examiner ARRIVA YERY PHERAL BISCASE Sequentially list conditions, if my leading to introduce cause. Enter Underlying Examiner Due to Datas have section over fi To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events JABRACH SIGH resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical PERLIPIDENIA Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 18-17-19-27 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of nin 24 hours after death.

the Funeral Director: After to a proper 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number MM P22220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4Radumpe 20110 31. Date filed (Month, Day, Year) State 2010 MAY 11 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Victor Joseph Vitkun May 2010 7:40 /Medical Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16515 Lappans Road Williamsport Washington 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F 91 116-22-7075 5, **Director** Jan. New York Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10g, Citizen of What Country? 10f, Zip Code 16515 Lappans Road Funeral 21795 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 194
If Yes, Give 11. Marital Status 14. Race - American Indian 1943 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No <u>ک</u> Specify 3 ☐ Widowed 4 X Divorced 1946 White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Supervisor</u> Energy Research permit. Pages 1 and 2 should be file Department of Health and Mental HI Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Vitkun Stephania Vebrlis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald J. Vitkun-Son 16515 Lappans Rd. Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Reg 4 ☐ Donation -6 ☐ Other (Sp Patrick's Cem. May 17,2010 Smithtown, New York 21. Signature of Funeral Serv Osborne runeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any least cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physician and the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ρ Month Day Year 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 → bnknown hash 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No this certificate Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural To the Hospital or Attendir
within 24 hours after death.
To the Funeral Director: All Completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 5, 2010^{ay} Dorothy Jane Windsor 5:30 Pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9211 Stewart Lane Road 349- A Clinton Prince George's Funeral 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Hours Min Nov 2, 1924 Virginia Director 219 56 1378 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Mariana. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George Clinton 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9211 Stewart Lane Road 349-A 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roby Monroe Jones Nola Tilla Tavlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Anne Wilson (Daughter) 6020 Federalsbury Hwy, Federalsbury, MD 21632 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Peter's Church Cemetery 5/11/2010 4 Donation 5 Other (Specify) Waldorf, Maryland 21. Signatur-Ineral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Ent sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or filure. List only one cause on each line use Inal Immediate Cause Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 4 ☐ Pregnant 9 ☐ Unknown g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 - No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifie 🗘 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Indical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated artifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month. Dav. Year) 10055120 ss of person who completed cause of death (Item 23a) (Type, Print) Jute 310 Was hing by DC 31 Date filed (Mor Registrar's Signature State Registrar

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State of Manyland / Department of Health and Mental Hydiene

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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
ledical Exami	ner	Lloyd	Willi		ty Town or Location of C	May 4, 201	0 4c. County of Death	2049 hrs
		 Facility Name (if not institution, give s Watkins Park Dr. & Centre 			ty, Town, or Location of D per Marlboro	peatn	Prince George	
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. las		Under 1 Year If Under 2 onths Days Hours		(MM/DD/YYYY) 9. Bir 6, 1955 Foreig	
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the Marylisa or 28a-f	Director	10e. Street and Number 12206 Hunterton	Street	10f.	Zip Code 20774		g. Citizen of What Cou United Stat	*
9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced If	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XX No Yes, Give Year r Dates:	If Yes, sp	edent of Hispanic Origin; ecify Cuban, Mexican, Pu 2[XXNo specify:	uerto Rican, etc.)	White, etc. Specify: Nata	^{can Indian, Black,} Black/India Ive American Lackfoot
5-0036 led within 72 hours. Hygiene. sother than "natur:	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	ual Occupation (Give kind working life. DO NOT use scaping/ Mu	e retired)	Agricul	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be		Watson Barret		Ve		arrett	
MD 2. nd 2 should alth and M m 27 is ma aumatic e	To		iams (Mother)	12206	ess (Street and Number Hunterton S	treet, Upp	er Marlbor	o, MD 20774
imore. Pages I ment of F tant: If i or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Cree		Ione Crematory	5/7/2010	20c. Location - City or Clinton, Ma	ryland
Balt permit Depart Impor injury	9	21. Signature of Funeral Service Licensee	5	Ferry I	and Address of FacilityLe Road, Clinton,	MD 20735		ld Alexandria
Physician Examiner			line. ead and Neck Injuries		de of dying, such as card	iac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
,	er	Sequentially list conditions, b	e to (or as a consequence of): e to (or as a consequence of):					
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of deat 9 Unknown	2 Fetal dea		egnancy	23d. Date of delivery Month E	ay Year
res that the signed by the lee detached	ξ	Part II. Other significant conditions co	ontributing to death but not res	sulting in the underly	ving cause given in Part I.		acco use contribute to	
of Vital Records, ing Physician: The law require Mer this certificate has been simeral director, page 2 should be	Completed					24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of s 2 No
	Be	25. Was case referred to medical examiner?	pital: 1 Innation 2 5		26.Place of Death (Ch			
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificity filled in by the funeral director,	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month. Day Year)	ER/Outpatient 3 28b. Time of Injury 2029 hrs	DOA Other No 28c. Injury at Work?	28d. Describe ho	esidence 6 🗸 Other w injury occurred ruck by motor vel	
Division ital or Attendius after death.	2 V Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town						eet and Number or Ru te) k Drive & Central Av	
the the	Medical C	one) 2 Medical Examiner: Or	To the best of my knowledge to the basis of examination and and manner stated					
To with To com	Me	29b. Signature and title of certifier	alla		29c. License number O.C.M.E.		29d. Date signed <i>(Mor</i> May 5, 2010	th, Day, Year)
BBB		30. Name and address of person who com Carol Allan, MD Assistant			t, Baltimore, MD 21	1201		·
St Regist	ate	31. Date filed (Month, Pay, Year) 2010	32. Registrar's Signature	Louis				
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the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 72 hours after nould be filed within 7.

Mental Hygiene.

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Important: If iter
any injury or oth

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Physician /Medical Examiner

the death certificate be executed burial-tran physician the as for use P.0. Vital Records, cate has been sig , page 2 should b

funeral director, After or Attending thours after death.

-uneral Director: Afely filled in by the fur the Funeral Directory filled in by Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Year Warren 6:03 PM Theresa 2010 Alice 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Center Medical Charles Civista Plata La If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Hours 1 □ M 2 🗓 F 214-32-8535 Maryland 73 /7/1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director Capital Heights Prince Georges Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 5757 Gladstone Way 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Completed by 3X Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 8 Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor P Dlorence Willie Ba11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5757 Gladstone Way, Capital Heights, Md 20743 Brenda Warren/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/14/2010 4 □ Donation 5 □ Other (Specify) Welcome, Md. Baptist Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bluford Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2019 Martin Luther King Ave., SE, Wash., DC MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) TERIOSCLEROTIC CARDIO VASCULAR DISÉASE PR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 □ DOA 211 No P 1 ☐ Yes 1 | Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D18545 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) OLDLINE CENTER WALDORF, MD 20602 NISOT 12070 32. Registrar's Signature State 1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3tiHW RODELL 8:18 6 W MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER ARUNDEL GLEY BURNIE BALTIMORE WASHINGTON MEDICAL ANNE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 10 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 923 Maryland 1⊠M 2□ F Months Days 86 216-12-6784 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showere the Medical Examinating that he notified at Director Maryland Anne Arundel 1 ☐ Yes 2 X No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Ritchie Hwy 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 27√2 No Specify. þ Specify: Black 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State Hwy permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnice. Elementary/Secondary (0-12) College (1-4or 5+) 7th 0 Highway Laborer Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John White ည Nettie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela White(Daughter) 908 Ritchie Hwy Severna Park, Md. 21146 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State Carpenter Hill 5 - 8 - 10Severna Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miniame Ind Addition of Pacili Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final Marshy Larry type **Physician** disease or condition resulting in death) VAQ 1 /Medical Examiner Due to (or as a consequence lef); Sequentially list conditions, if one had in a Limmodul cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a ginsequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Tyes 2 No 3 Probably 4 W Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1 ∐Yes 2 XNo director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Is Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) De Chicanus La Craischoca MAY1,2010 POOESTIL WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ·U

State Registrar CUILLER MO JOSÉ GIAN ERECO

MAY 0 7 2010

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

301 Hospital Dr. Glen Burnie, Md. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6239PM James Steed Watson 100 ,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner en Anne Burni Baltimore Washington Medical Center If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2 F Months Days Hours Min. 214-34-3505 Director July 7, 1938 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinator ust be inclined at any Injury or other traumatic event, the Medical Examinator. 10d. Inside City Limits Director 1 ☐ Yes XXNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Lori Dr. Apt. D 21061 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 1 Never Married 2 Married 2□No 60-62 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No δ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Earl Watson Sr. Henrietta Elizabeth Steed ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Watson Jr. (brother) 221 Arundel Rd. Riviera Beach, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/6/2010 Glen Burnie, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis RD Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cam Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>る</u> í¶X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1° Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide figertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 040M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Knoll Wood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Hours Days 1 ☑ M 2 ☐ F 61 214-50-2694 Maryland Oct. 08,1948 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a, State Millersville Anne Arundel 1 ☐ Yes 2 No MD 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 899 Cecil Avenue 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☑Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 No White Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Claims Adjuster 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry G. Welch Angela L. Wineke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Green Aspen Court Millersville, MD 21108 19a. Informant's Name/Relationship (Type. Print) Mary Angela Zerhusen / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2010 Baltimore, MD 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last)Iapttts Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Hygiene.

1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than

permit. Pages 1 and 2 & Department of Health ar Important; If Item 27 Is any injury or other trau

Baltimore, Maryland 21215-0036

Examiner the attending physician and thed for use as the burial-trans Physician/Medical signed by the a þ Completed page To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be ၉ Certification:

neec

has

certificate

1 Natural 2 ☐ Accident 5 | Pending investigation 3 ☐ Suicide

6 Could not be determined 4 Homicide

Injury

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b, Signature and title of certifier

29a. Certifier

(Check only

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed ive Eknoge Manyland 21075

State Registrar

Medical

31. Date filed (Mon

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours a To the l within 24

> State Registrar

29b. Signature and title of certifier

Hall Hylmay, Conifield MD 21817 aumbunallar

0

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

29c, License number

D 48098

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Mildred Webb 10:50 J. РМ Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care- Largo Largo Prince Georges Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth **Funeral** g. Birthplace (State or Foreign Country) V<u>irginia</u> 1 □ M 2X F Months Davs Hours Min. 227-14-8872 Director 94 Usual Residence of Decedent show 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Largo Road 20774 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Black, White, etc. Armed Force If Yes, specity Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by 1 Yes 2 2 🕅 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Substitute Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Maclin Willie Mae Armstard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alwyn Jackson / Son P.O. Box 4997 Capitol Heights, MD 20791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-10-2010 Hopewell, VA City Point National 4 Donation 5 DO Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Si produr un ral Service Lo 3401 Bladensburg Rd Brentwood, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Cardiac Arrhythmia Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of); Examiner Coronary Cardiac Disease Sequentially list conditions, lany, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a exhaeousnes, on Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death g ☐ Unknown Month Year Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 24 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical

State Registrar

Ceil George, MD 7500 Hanover Parkway 31, Date filed (Month, Day, Year)
MAY 1 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenbelt, MD 20770

1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

05-06-2010

29c, License numbe

D58182

29a Certifier

(Check

only one 29b. Signature and title of certifi

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 11:37 PM DAVID WELLS 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b City Town or Location of Death 4c. County of Death Examine Regional Hospital Prince George's Laure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2 □ F 580-14-3342 63 Director October 2, Trinidad 1946 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. In Mich I worther must be notified at 10a State 10b. County 10c. City Town or Location 10d. Inside City Limits Director MD Prince George's Beltsville 1K Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4716 Cardinal Avenue 20705 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ∏Yes 217 No. Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Courier Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theophilus Wells Constance Francis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wyntris Well - Wife 4716 Cardinal Avenue, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Chesapeake Crematory May 12, 2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral German Commen 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiorespirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic ancer. attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending after death.

| Director: Aid in by the fu investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after e Funeral Dire McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27916 7300 Van Dusen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas H. Burguieres Regional Hospital Laurel 20707 31. Date filed (Month, Day, Year) State MAY 1 1 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MPR'IL 29 2010 ear FLORENCE 16:20 P M WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. NOV. 14 Year) VÍRGINIA 231-50-9792 70 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director PRINCE GEORGE'S TEMPLE HILLS MD 1 Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2718 BELL BROOK STREET 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "topologie." (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CASHIER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILTON SCOTT **EVELYN** FREEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2718 BELL BROOK STREET TEMPLE HILLS, MARYLAND 20748 SOPHIA WILLIAMS/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD VETERANS CEMETERY 5/10/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit COCI UTI and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy page 2 death? 1 Yes 2 No 1 ☐ Yes 2 🗓 No **Division of Vital** Be 25. Was case referred to medical After this certific funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 Ϊ No မ 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending death. nours after death. neral Director: A I filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and t e of certifie 29d. Date signed (Month, Day, Year, D63639 041 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTHU RAJU NAGABHYRU M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 32. Registrar's Signature 31. Date filed (Month, State MAY 1 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vernon Lerov Wiles au Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 6. Sex 1**XX**M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days June 27,1941 213-40-4239 Maryland Director 68 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Williamsport 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 12016 Kemps Mill Road 21795 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? 1424Yes 2 \(\subseteq No \) 1962-Black, White, etc. 1 Never Married 2XX Married 2 Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", If Yes Give Specify: 3 Widowed 4 Divorced 1968 Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Towing Rescue Equipment Project Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Wiles Lucille Leroy Georgia permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred J. Wiles - Wife 12016 Kemps Mill Road Williamsport, Maryland 21795 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (See Cedar Lawn Mem. Park May 12,2010 Hagerstown, Maryland 21. Signature of Fy sborned Aftereradity Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical that the death certificate be 68760 as IF FEMALE use fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed aremore a prostate 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗖 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral programmer. 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0-2062 1 oschard terrice Rd

DHMH 17 Rev 7/2009

State

Registrar

2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year ANNA CECELIA 09:40 A-M MA /Medical 2010 4a. Facility Name (If not institution, give street and number) THBCC 4b. City. Town, or Location of Death 4c. County of Death Examiner CIT JOHNS HOPKINS BAYVIEW LARE CENTER ALTIMOR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace *(State or Foreign Country)* Maryland 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 214-20-2430 84 Dec. Director 13,1925 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Evan that Le notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 764 Fulbrook Road 21222 United States 'natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years s 1 and 2 should be filed wi f Health and Mental Hygier ttem 27 is marked other th Telephone Operator C & P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emory Norris Anna Kaufmann ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland L. Aldao 8603 Hickory Thicket Place Nottingham, MD 21236 permit. Pages 1 and Department of Heal Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Garrison Forest V.A. Cem. 5/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD ^{22. Name and Address of Eacility}
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Signature-of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. ZND STAGE MULTI-INFARCI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed CEREBRA VASCULA sician and burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 1 ☐Yes 2 No detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALTIMORE HOPK IEW RC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 24, William Joseph Adams 2010 2:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3939 Roland Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 ☑ M 2 🗆 F 212-36-9141 71 6, 1938 **Director** Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show er than "natural", or items 23a or 28a-f sho Director Maryland N/ABaltimore 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3939 Roland Avenue #308 21211 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc Armed Forces within 72 hours after 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Druid Ridge Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmasts. 12 Grounds Keeper Cemetery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Henry Charles Adams Mary Anna Hershey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Adams Wife 3939 Roland Avenue #308, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Donation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druid Ridge Cemetery 5/28/2010 Pikesville, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 21211

23a. Part 1. Enter the disease, or complications that caused the death. Shock or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burish-transit completely filled in by the tuneral director, page 2 should be detached for use as the burish-transit Box 68760, € Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 🗆 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 1 ∐Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Ceath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Natura 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated) Medical 29a. Certifier 29b. Signati 29c. License number 29d. Date signed (Month Day, Year) dress of rson who complete cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month William Matthew Albrecht 20ay 20To 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 600 Pamela Road Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Months Days May 13, Year 955 55 **Director** 215-64-3244 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2\(\bar{\cap}\) No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Pamela Road 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 9 1 Never Married 2 X Married ☐ Yes 2 XNo 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Associate Johns Hopkins Applied Elementary/Seconday (0-12) College (1-4 or 5+) 10 Professional Staff Member Physics Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albrecht Magdlyn **Hollifield** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Albrecht / Wife Pamela Road Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Small Cell lung Cancer-with disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Brain and liver metestasis 14 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 X Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Funeral Director; After this certificate completed filled in by the funeral director, pag 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? XNatural injury 5 Pending 2 🗌 No Accident Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature 29c. License number 29d. Date signed (Month, Day, Year) MO D38509 May 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V Nicholas W. Koutrelakos M.D. 10710 Charter Drive Suite G020 Columbia MD 21044

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day May 17, 2010 1009 hrs **Medical Examiner** Norma Jean Banzaca 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5821 Rowanberry Dr. Elkridge Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Davs Months Hours Director August 22, 1960 Country) England 220-90-2288 1 M 2 X F 49 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Yes 2 x No 23a or 28a-f show notified at once, Maryland Howard Elkridge permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A. 5821 Rowanberry Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No White Specify: 3 Widowed 1 Yes 2 X No specify: 4 Divorced f Yes. Give Year ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Sports and Entertainment 21215-0036 11 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Beverly Hover Leonard Banzaca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Finn Lane Apt#1833 Charlotte, North Carolina 28262 Tiffany Banzaca (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State timore, crematory or other place) Burial 2 X Cremation 3 Removal from State Atlantic Crematory 5-20-2010 Glen Burnie, Maryland Donation 5 Other Specify 22. Name and Address of Facility Witzke Funeral Homes, Inc 21. Signature of Funeral Service Licens 5555 Twin Knolls Road Columbia, Maryland Part I. Enter the se, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause in each line. /Medical Death Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit X AMENDED 4a 23a, **4a per me g903 5-26-10 vt** 3a, PII, 27, per ME g904 6/3/10 TT Physician/Medical X UNPENDED attending physician or use as the burial -Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Lupus Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of s certificate has b rector, page 2 sh performe death? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other | Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this ۵ 1 Yes No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Yes 2 No Pending 2 Accident Investigatio 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD.

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State Registrar 31. Date filed (Month, Day Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 1205 M ridges 21 2010 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Wrsing ente imore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 212-09-9531 9, Director Nov. 1917 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County Show 10d. Inside City Limits items 23a or 28a-f shart representations 1 ☐ Yes 2X No Director Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4407 Fenor Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the "Modell Exen," any injury or other traumatic event, the "Modell Exen," office. Baltimore, Maryland 21215-0036 δ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hamme 1 Mary Fay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Bridges/ Son 4407 Fenor Road<u>, Halethorpe,</u> Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/22/2010 Baltimore, Maryland 22. Name and Address of Facility Cremattion Society of Maryland, Inc. 21. Signature of Funeral Service LicenseeAmanda Heaston 299 Frederick Road,Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician men disease or condition resulting in death) /Medical Due to (or as a consumuence of): Examiner orona ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans evis and Due to (or as a consequence Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical Edi IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Ye ar 5 Other (specify) the detached ģ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ other dism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 ☐ Yes 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary 3320 ms Benson 31. Date filed Month, Day, Year) 32. Regis

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DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BERMAN MYRON **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Vantage House 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Nu 152–14–6405 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 7/13/1912 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits Florida Sarasota Sarasota Director 1X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 770 South Palm Avenue, Apt. 404 34236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 √ Yes 2 No If Yes, Give Year or Dates: W 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Attornev Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isadora D. Berman Henrietta Sigmeister ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Berman / Son 10320 Old Frederick Road; Woodstock, MD., 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 T Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 5/18/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) + AILLRE ONGESTIVE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

> 10 Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETT GEH, MD 300 ARMORY PLSVITE 36 ISALTIMORE MD 21201-

29c. License number

D53580

29d. Date signed (Month, Day, Year)

Physician/ al Examiner OSCAR ARMANDO BONILLA 2. Date of Death Month Day May 15, 2010 4a. Facility Name (if not institution, give street and number) Point Lookout State Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 8. Date of Birth (MM/DD/YYYY) 8. Date of Birth (MM/DD/YYYY) 8. Birthplace (State or Excession)	753 Bonilla		Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and Certificate of Death	Mental Hygiene 2010 619
The filling have not first residuation, give stored and numbers) Point Lockout Same Print Cook State Park South State Park South State Park South State Park South State Park South State Park State Park			1. Decedent's Name (First, Middle,Last)	Month Day Year
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The State IDE County The Street and Number The St	Funeral Director		NONE 1 X M 2 F 26 Yrs. Months Days	Hours Min Foreign
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The part of the pa	be filed within 72 hours aft ntal Hygiene. rked other than "natural" ent, the Medical Examine		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life. D	(Give kind of work done D NOT use retired) 16b. Kind of Business/Industry
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238 Part L Enter the offease, or complications final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line immediate Cause (Final disease or complication resulting in death) Due to (or as a consequence of):	Pages I and ent of Healt nt: If item		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemei crematory or other place)	ery, Date 20c. Location - City or Town, State E1 Salvador
Sequentially late cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine immediate Cause (Final disease or conditions, if any, leading to immediate cause (Final disease or conditions) Due to (or as a consequence of):	ermit. F Departme mportal		21. Signature of Funeral Service Licensee 22. Name and Address of	Facility Santa Cruz Funerales Latinos,
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	ch as cardiac or respiratory arrest, shock, or heart Approximate Interva
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	t the dea by the a ached fo			n in Part I. 23e. Did tobacco use contribute to the cause of death?
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	The law req	Complet		autopsy prior to completion of cause of performed? death?
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	ysician; his certi director	Be	examiner? Hospital: Oth	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	ending Phyath. ath. or: After tl the funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at 1815 hrs 28c. Injury at 1815 hrs 1 Yes	t Work? 28d. Describe how injury occurred
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	pital or Att ours after de leral Direct filled in by	Certifica	3 Suicide 6 Could not be determined (Specify) Bay	or Town, State)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2010	the Hos hin 24 h the Fur	lical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	
30. Name and address of person who completed cause of death (Item 23a)	To To CONT	Mec	and manner stated.	umber 29d. Date signed (Month, Day, Year)
			Willand fre Isile	May 16, 2010
	'			more, MD 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti **2**010 5:36 Emma A. Bredehoeft Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🔀 F Months Days Hours Min 93 **Director** <u> 214-01-2745</u> Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State Director 1 Yes 2 X No Parkville Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21234 8820 Walther Blvd. Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed White er than "natur the Medical B Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) American Can Company Office Clerk 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matilda Renz Louis Bredehoeft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 1331 Baltimore, Maryland 21234 8820 Walther Blvd. <u> Mrs. Bertha Fenwick - Sister</u> Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 05-25-2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Live 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ debilter disease or condition resulting in death) Medical Due to (or as a convequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be 2 XNO Other: ပ္ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direct filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:12AM sel 3010 leanor /دن Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death echucu If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min Yrs. Director toher 13,19 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Examiner must be notified 1 Yes 2 No ь 10e. Street and Number 10g. Citizen of What Country? 23a 21601 items 12. Was Decadent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ dex i 19a. Informant's Name/Relationship (Type, Print) dayhter 2160 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or other traionce. 80 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8434 21. Signature of une al Service Ucense 22. Name and Address of Facility 1935 23a. Part 1, 5 fer the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shoot or heart failure. List only one cause Immediate Cause (Final .Physician/ prebrovascu disease or condition resulting in death) Medical Duetto (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consumence of Exami use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. performed? Yes 2 No 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 05-21-2010 who completed cause of death (Item 23a) (Type, Print) Easton, MD 21601 204 Grady Do 8221 ea 31. Date filed (Month, Dav., Year) State

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Beatrice L. Butler 10:17PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death imore Saint Joseph Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 220-24-6242 1 □ M 2**X** F Months Davs Hours Min. 79 Balt Maryland 7/16/1930 Director Usual Residence of Decedent show 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Baltimore Towson 1 Yes 2XXNo 10e. Street and Numbe 10f. Zip Code 10g_Citizen of What Country?
United States Funeral 1 Smeton Place Unit 704 21204 of America items "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No- Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married 1 Yes 2XNo Baltimore, Maryland 21215-0036 white 1 Yes XX No Specify: 3X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Francis O'Neill Leona Jane Cochrane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Jeanne L. Cahill/ daughter 7 Clipstone Court Baltimore, Maryland 21236 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 25, Dulaney Valley Memorial Gardens 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, Maryland 4 Donation 5 Other (Specify) 2010 permit. 21. Signature of Pungal Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
Peaceful Alternatives Funeral & Maryland 21093 Timonium, 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ANOXIC ENCEPHALOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDIAC ARREST ASYSTOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ANAPHYLAXIS the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year ed by the a detached i g 🗌 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 X No 1 Yes 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 ပ္ npatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 7601 OSLER DRIVE TOWSON , MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO M. D.

31. Date filed (Month; Day, Year) - -

10-03812 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Allan Bethea State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 18, 2010 1435 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** St. Joseph's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 1 M Country) 2 F Yrs 10d. Inside City Limits 10a State 10b. County 10c City Town or Location 1 Yes 2 No marked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Higgiene.
Importment If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Yes, Give Year 4 Divorced 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Indust Completed during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) å (Street and Number or Rural Route Number 14734 Uren Place of Disposition (Name of cemetery, 20e. Location - City or Town, State 2 Cremation 3 Donation 5 Other Specify e of Fune Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** Between Onset and /Madica Death a.Atherosclerotic cardiovæscular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED 23a,27,perm,E g904 6/1/10 X UNPENDED signed by the attending physician be detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 P ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural

Division of Vital

State Registrar

Theodore M. King, Jr., MD. 2°onth,

5 Pending

6 Could not be

Investigation

determined

Accident

Suicide

Homicide

29b. Signature and title of certifier

30. Name and address of person

Assistant Medical Examiner 32. Registrar's Signature

completed gause of death (Item 23a)

and manner stated

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

1 Yes 2 No

OCME

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

May 19, 2010

29d. Date signed (Month, Day, Year)

or Town, State)

Director:

To the

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Drexel Burke, Sr. 20 2010 Medical May 5:35 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days MD Country) XX M 2 G Hours Min. 213-38-7874 68 **Director** 14 1941 Usual Residence of Deceden or 28a-f show notified at 10a. State 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1XXYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 1313 Clipper Heights Avenue 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XXMarried by 1 Yes 2 Your of Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life, DO NOT use retired)
Auto Worker Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant; If item 27 is marked other than lury or other traumatic event, the N General Motors 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alan C. Burke Dorothy Leona Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Burke (Wife) 1313 Clipper Heights Avenue Balto, MD Department of Health Important; If item 2' any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 5/25/10 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility3631 Falls Burgee-Henss-Seitz Funeral of Funeral Service Road Balto, Home, Inc. MD 21211 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CANCE -UNA disease or condition 2009 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of). sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit e Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.

Puneral Director; After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 4 Pregnant at time of death 9 Unknown Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗆 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NONAPLES ST, SUITE 4105 BALTIMONEIMO 21204 DANIEUE-DOBERMAN MO

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Robert Т. Brown Month Mav 19 1:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 220-22-4276 1 🖾 M 2 🗆 F Months Days Hours Director 81 07/28/1928 MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firen 27 is marked other than "natural", or items 220 common any injury or other transments. 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Baltimore Lutherville MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 West Seminary Avenue 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: Year or Dates, US Marines 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roland L. Brown Sr. Mariana R. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Batavia Avenue, Baltimore, MD 21214 Michael D. Brown / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 5/20/2010 Woodbine, MD 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility emation Services 18hall PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0515 Medical Due to (or as a consequence of): Examiner crotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Due to (or as a consequence or, Phriphral attending physician and for use as the burial-transi Vascula that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Year the 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown s been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b lirector, page 2 sh autopsy performe death? Yes 2 X N 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director; filled in by within 24 ho

To the Fune

completed fi

State Registrar DHMH 17 Rev 7/2009

Medical

4 Homicide

29a. Certifier

(Check only one

Marian

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

determined

Grant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28569

N. Charles

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R149194

Towson, MD

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21204

may 19,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:18 AM 2010 Bolywatife Dabaturrle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Georges MOSD I tall Birthplace (Clate or Foreign Country) Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 48 Year) 12 M 2□ F Days NONE 05/10/2010 Director laryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Midical Examiner must be notified at 1 Yes 2 □ No Funeral Director aurel Frince George 10g. Citizen of What Country? 10f. Zip Code ö Inited States 9111 Contre Rd. A 20708 pt301 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Heme 27 any Injury or other traumatic. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nfant INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Olatunde Oludayo OKuszyna)/ada 40 Babatunde ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9111 Conke Rd. Xpt301 Vlaturde Okusayna Mother Laurel MU 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Signature of Funeral Servi 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Sause (Final disease or condition resulting in death)

a. Extreme Phematurity Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as e consequence of): Examiner hem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of ceuse of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed certificate 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 014774 5-11-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAN DUSEN 20 Laurel 420. SHAHID HZIZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 18 2010 ALBERT BURGESS CAMPBELL, JR 3:26 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Sep. 10,1945 **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months Hours Country) Virginia Director 228-64-8746 Yrs. 64 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No VA Fauquier Bealeton 10e, Street and Number è 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral with 11156 Willow Drive, Apt. J 22712 USA . Page 1 and 2 should be filed within 72 hours after death iment of Heath and Mental Hygiene. Fant if frem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1978-If Yes, Give Year or Dates 1 Yes 2 No Specify: Black 3 Divorced 4 Divorced Specify: Completed 1984 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Security Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Grant Albert B. Campbell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu 11156 Willow Dr., Apt. J, Bealeton, VA Doris A. Campbell - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spe Culpeper Nat'l Cemetery 5/24/10 Culpeper, Virginia . Signature of Juneral Service 22. Name and Address of Facility Joynes Funeral Home, Inc. noun 29 North 3rd Street, Warrenton, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition DIFFUSE LARGE B CELL LYMPHOMA / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events southing in dooth). Examine Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? 1 ☐ Yes 2X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 🔀 No Other: ဂ္ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direct determined City or Town, State edical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 0102201805 (VA)

Registrar DHMH 17 Rev 7/2009

State

backer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LCDR MC USN

32. Registr r's Signature

DANIEL KIM

31. Date filed (Month, Day, Year)

2010

20

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g905 7-15-10 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cole Physician/ aniel Month 22 Day 2090 6:30 AM Medical 4a. Facility Name (if not institution, give street and number).
Loch Roven Community Living Examiner Town, or Location of Death 4c. County of Death Center N If Under 1 Year If Under 24 Hrs. 8. Date of Bit Yeartha Days Hours Min. Month, But Ye 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Months Director 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No ma 10e Street and Number 10g. Citizen of What Country? Funeral USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Bla 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+ Laborer Be 17. Father's Name (Figst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code, Marian moore-Meles 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 128 Burial 2 Cremation 3 Removal from State To cost les 6-1-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 3:405 600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faily e. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Fina vostate ancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 prior to completic death? certificate 1 Yes 2 No Yes 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: LRCLC 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending iniury Accident Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D41365 29d. Date signed (Month, Day, Year, May 22, 2010 3900 Loch 11 Battimore theme and address of person who completed cause of death (Item 23a) (Type, Print) Bouleyard t Jeovas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type of Print in Black Indelible inky Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Creek I Milton Creek II **Physician** 4:55 AM 2010 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Multimedical Center 7700 York Rd TOWSON, Maryland 21204 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-24-6455 Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No
Yes, Give
Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Black 1∐Yes 2¶No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Her Carrier Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname, Informant's Name/Relationship (Type 06 Strect Baltimore 20c. Location - City or Town, State
Raltimure, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Inature of Funeral Service Tensee roximate n erval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician failure ×4/5/2010 Acute on Chronic renal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Intracerebral hemorrhage 2006 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Persistent Vegetative State; Ornonic Respiratory Failure; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Institutional Ileus; Type II Diabetes Mellitus; Seizure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 25. Was case referred to medical examiner? certificate 2 WNo Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🖼 📆 🗸 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Nuse Practitioner ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ► Michelle E. Kalender CRNP R097104 may 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genesis Multimedical Center Michelle E. Kalendek, CRNP 1700 York Rd. Towson, Maryland 21204 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 805PM Tarriet hristian 2 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN Square Hospital Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth 1 □ M 2 KF Months Days Hours Min Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Station Director 1 □Yes 2 No lurners 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avondale USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Department of Health and Montal Hygiene. Important: If them 27 is marked other than "natuany injury or other traumatic event, I'm Inclination." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ecurit 17. Father's Name (First, Middle, Last) oore 19b. Mailing Address (Street, and Number or Rural Route Ny 19a, Informant's Name/Relationship (Type. Print) Street 180 Himore Md. 2223 Daughter S. Stricker Christian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematery or other place, 1 🗆 Burial 3 Removal from State 2 Crom 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disseminated intravascular coaquitation disease or condition resulting in death) Due to (or as a consequence of): DISEase LIVER hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 →No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RESOCOO

DR

29d. Date signed (Month, Day, Year)

5/24/10

Balto md

Examiner Box 68760. P.O. I Records, of Vital Division

law requires that the death certificate be executed physician and the burial-transi attending physician for use as the burial ed by the a s been signed be should be deta has page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician

/Medical

Funeral

Director

28a-f show

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23a

items ?

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"natural"

Baltimore, Maryland 21215-0036

other traumatic event, the Mcdical Examinar quet be notified at

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAY 25 2010 Genera



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ John R. Caron 2010 12:42 P.M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Stella Maris Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, June 23 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Year) Director 469-32-5463 78 Minnesota June Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Examiner must be notified at Director Harford County Maryland Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 403 Mauser Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural" 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Engineer Ingersoll-Rand Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lydia Rehman Gervase Caron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Arlene Caron (wife) 403 Mauser Drive, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 18, 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 21,2010 Forest Hill, Maryland Funeral Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - 1 3 Newport Drive, Forest Hill, Maryland 21050 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PULMONARY FIBROSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached 1 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 X No 2 \square No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Detailed Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Acciden Investigation 6 Could not be Accident Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2010 141 of person who completed cause of death (Item 23a) (Type, Print) JONES. 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Mohth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sally Marie Crowley MAY $2^{\frac{10}{2}}$ 20°T0 5:07 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL TOWSON CENTER Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months 1 □ M 2 X F Hours 85 163-20-3520 Director Pennsylvania March 3 1925 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Baltimore Towson MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Fellowship Court Apt. F 21286 Funeral U.S.A "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Campfield Vocational al Hygiene.
I other than "
vent, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher School permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Salvatore Bellomo Giovina Andolfi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Crowley/ Son 3012 Glenmore Avenue, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel – Bel Ai 1 Burial 2 XCremation 3 Removal from State Forest Hill, MD 4 Donation 5 Other (Specify) of Funeral Service Licensee Signat 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd Parkville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death im e nate Cause (Final CARDIOGENIC SHOCK Physician/ dispare or condition Medical resulting in death) Due to (or as a consequence of): Examiner 6 VENTRICULAR FIBRILLATION CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death ed by the a detached f g 🗌 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ANOXIC ENCEPHALOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should by 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending injury work? 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29c. License number Date signed (Month, Day, Year) D 35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA FREDA BARR, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Repistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

0-03869 Brian Conklin		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
onan Conkiin		1-For State Crivial yland 7 Department of Certificate of Registrar			201	0 1620				
Physicia	in/	Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death				
Medical Exami	ner	4a. Facility Name (if not institution, give street and number)	o. City, Town, or Location of Death	May 20, 20	4c. County of Dea	1949 hrs				
		Saint Agnes Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or				
Funeral Director		200-46-0698 1XM 2F 55 Yrs.	Months Days Hours Min	_		eign Pennsylvania country)				
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits				
* .	٦	MD Baltimore Pa	rkton			1 Yes 2 No				
Marylan r 28a-f s	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Co	untry?				
vith the last state or state o	a D	5 Twin Oaks Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21120 Decedent of Hispanic Origin? (Si	pecify Yes or No-	USA 14. Race - Amo	erican Indian, Black,				
leath w	Funeral		s, specify Cuban, Mexican, Puerto		White, etc.	ite				
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify:					
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin			s Usual Occupation (Give kind of st of working life, DO NOT use ret		16b. Kind of Busines					
036 ithin 7, ne. r than	Completed		hnical Traine	r	Pest Co	ntrol				
15-0 filed w Hygie d other		17. Father's Name (First, Middle, Last)	18.Mother's Name							
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To Be	Laverne J. Conklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Joanne Address (Street and Number or I	nne McManus per or Rural Route Number, City or Town, State, Zip Code)						
O \(\tilde{E} \)			n Oaks Court-							
Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Evans Fune.	ion (Name of cemetery,	Date	20c. Location - City					
Baltimore, permit. Pages I an Department of He Important: If ite Injury or other tr		4 Donation 5 Other Specify: and Cremat	ion Ser Belair		Forest Hill	,Maryland				
Balt permit. Depart Impor	d	21 Signature of Funeral Service Licensee 4 Eva Fya 169	ns Funeral Chape 24 York Road-Mor	el and Ci	remation S	ervices				
Physician	Ť	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and				
Examiner	P	Immediate Cause (Final disease a <u>Hypertensive</u> atherose	lerotic cardiov	ascular	disease	Death				
14 (20)		or condition resulting in death) Due to (or as a consequence of):								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
0 =	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
xecuted and transit	calE	d.								
7 8 8 8	edic	IF FEMALE: AMENDED 23a, 27, permE, G904	5/1/10 TT		23d. Date of delive					
Box 68760, e death certificate be the attending physic ed for use as the burned for use	Physician/Medi	23b. Was decedent pregnant in the nast 12 months?	al death 3 Ectopic pregna	ancy	Month	Day Year				
OX (leath ce e attence for use	sici		er (Specify)							
		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.			to the cause of death?				
Division of Vital Records, P.O. tal or attending Physician: The law requires that the stare death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by					obably 4 V Unknown				
Vital Records, sysician: The law requir his certificate has been so director, page 2 should	Completed			24a, Was ar autops perforn	y prior to	autopsy findings available completion of cause of				
Rec : The ificate		OF Western Standard Standard	26.Place of Death (Check	1 Yes 2	No1 ✓	Yes 2 No				
/ital	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other []		Residence 6 Oth	er;				
of Ving Phy	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of In		28d. Describe ho	ow injury occurred					
ivision or Attendi after death. Director: I in by the f	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	29f Loantion (Ct	reat and Number or I	Rural Route Number, City				
Division of Piptal or Attending Phours after death. Ceral Director: After tiffled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)	, ractory, office building, etc.	or Town, Sta		Rufal Route Number, City				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr	ed at the time, date and place, and	due to the cause	(s) and manner as st	ated.				
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (May 21, 2010	ionin, ⊿ay, Year)				
4		30. Name and address of person who completed cause of death (Item 23a)								
Ų		Carol Allan, MD Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 2120	1						
St Regist	ate									
regis	TELL.	HAI AU CUIU CONTON TO TO								

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OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert John Cashen Sr. 1:56P M May 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 330 Gatewater Court Apt. Glen Burnie Anne Arundel 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea **Funeral** Months Days Hours 1 X M 2 □ F 72 Altoona, PA **Director** 215-34-0316 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2XXNo MD Glen Burnie Anne Arundel ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 330 Gatewater Ct #102 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 0 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Printing Co. 12 Foreman Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Biselli Edward Cashen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert J. Cashen, Jr. / Reistertown, MD 21136 Son 19 Waugh Ave 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/24/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Signatur of Funeral 22. Name and Address of Facility Singleton Funeral and Cremation 1 2nd Ave SW Glen Burnie, MD 21061 Services, PA M01220 23a. Part 1. Enter the conshock, or heart faile asse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Onset and Ph sician/ Acute Mdisease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DISCHSI SURUWARY ALTUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on: and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death by the a | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seutre Cupp 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🔼 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending injury 2 Accident Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar DHMH 17 Rev 7/2009 (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

will Eldoub

WILLIAM E. RANDALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mn

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

808210000

33

YURIR RA

29d. Date signed (Month, Day, Year)

Lutherville Mu 21093

5-24-10

29c. License number

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5130AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4128 The Alameda n/a Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 228-38-6772 Months Days Hours 1 ★ M 2 □ F 74 23,1935 Director July Virginia Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits id other than "natural", or items 23a or 28a-f sho event, its wordon Evar, it we must be notified at Director MD n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 4128 The Alameda 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify \$ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10th Laborer Bethlehem Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H em 27 is marked ott Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewe once. Harry Claiborne Vearlie Prince ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Claiborne (wife) 4128 The Alameda Balto, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Donation 5 ☐ Other (Specify) Memorial Pk. May 28, 2010 Baltimore, Md. gnature of Funeral Service Licenses ²² Name and Address of Facility Calvin B. Scruggs Funeral Home Preston St. Balto, Md. E 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiag or respiratory arrest, Immediate Cause (Final Carcei **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ficate has been si , page 2 should b 1 ☐ Yes 2, ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2, ☑ No 2 No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending To the within 2

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

020396

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

24, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

Placen Blud. Be Hinore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryland		artment of F				ene 0	0	162	13
			1. Decedent's Name (First, Middle	Last)			-		2	Date of Death	1		3. Time o	f Death
	Physici /Medio		AMERICA FLORENCE D	UNN						Month MAY 1	Day 6. 2010	Year	912	рΜ
	Examir		4a. Fecility Name (If not institution,	give street and nu	umber)		4b. City, Town, or	Location o	of Death		4c. County of	f Death		
			FAIRFIELD NURSING	AND REHAB				WNSVIL			ANNE	ARUNI	DEL	
	Funeral Director		5. Social Security Number 579.10.2818	6.Sex 1 □ M 2 X XF	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, 1AY 16, 1	Year)	9. Birthp Coun	lace (State etry) VA	or Foreign
	pue *		Usuel Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					1	0d. Inside C	Site I Sanita
	aho	ŏ										'		XXINo
	28e-1	ect	MD ANNE 10e. Street and Number	ARUNDEL	(CROWNSV	10f. Zip Code			10	Or Citizen of 141	hat Caus		7,5
	with se or	ā	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co								nat Cour	iuy r		
	ne 23	era	1454 FAIRFIELD LOO		cedent Ever in U.S	3. 13.	2103 Was Decedent of H		gin? (Specif	v Yes or No-	USA 14. Bace	- Americ	an Indian,	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, I'm Medical Exaction must be rediffed at ODGe.	by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3√√ Widowed 4 ☐ Divorced	Armed F	orces? 2 /(X No iive	1	f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	in, Mexican Specify:	, Puerto Rio	ean, etc.)		, White,	etc.	
21215-0036	2 hou	pe	15. Decedent	s Education	1	16a. Deced	ient's Usual Occup	ation		1	6b. Kind of Bus			
215	hin 7.	Completed	(Specify only highes: Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give life. i	kind of work done on OO NOT use retired	du <i>ring</i> most ()	t of working				,	
2	giene Trh	mo.	unk	Conage	(1 401 5+)	CAR	EGIVER				SELF E	MPLOY	/ED	
	at Hy Toth	Be (17. Father's Name (First, Middle, L	ast)				18. Mothe	r's Name (/	First, Middle, M	laiden Sumame			
<u> X</u>	Ment Ment arked	To E	EDGAR R. EUTSLER					CE	CILE GA	RBER				
Maryland	2 sh and is m		19a. Informant's Name/Refationsh	ip (Type, Print)			g Address (Street				City or Town, S	tate, Zip	Code)	
	t and tealth im 27 her t		T. JOHN KELLY		SON		BOX 203, B	OWIE, 1						
Baltimore,	if it of the or of or of		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from	State	metery, crer	sition (Name of natory or other plac		Dat		0c. Location - 0		wn, State	
ij	rt. Pe		4 □ Donation 5 □ Other (Sp	ecity	BAY	-	EMATORY INC		MAY 18,	2010	BALTIMORE	, MD		
Ba	Depariment impo		21. Signature of Funeral Service L	FINK	M01148	3 1	Name and Address INK FUNERA	L HOME WY, S.	P.A. GLEN	BURNIE,	MD 21061			
			23a. Part1. Enter the disease, of shock, or heart failure. List	on plications that	caused the death.	Do not ent	er the mode of dyin	g, such as	cardiac or r	espiratory arre	st,		Approximation	tween
	Physician	Ì	Immediate Cause (Final disease or condition	. Aci	hintra		heamon					-	Onset and	Death
	/Medical Examiner		resulting in death)	Duerto	(or as a conseque	ence of):	Table 1	CH						
		_	Sequentially list conditions,	b	shhope									
	led	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Dueyto	or as a conseque	ence of):								
0.	and al-trar	хап	that initiated events resulting in death) Last	c. <u>Due to</u>	(or as a conseque	ence of):								-
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Вох	andin use	M/u	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnan birth 2 ☐ Fetal o						23d. Date	of delive	ry	
	The law requires that the death centif ite has been signed by the attending bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No		nant at time of dea		Ectopic pregnancy Other (specify)				Mont	h	Day	Year
о. О	at the	ڇ	9 Unknown											
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ခိုင	e law has t	Completed	talure to the	rue:						24a. Was an autopsy	pr	ere autori or to con	osy findings apletion of c	available ause of
<u>=</u>										perform 1 ☐ Yes 2		ath? Yes	2 No	
Ž	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar:		check only one	ne)			
ō	g Phy ler this heral di	٤	1 inpatient 2 in inpatient 3 in DOA and 4 Maintaing Home 5 Residence 6 Other (Specify)							")				
o	th.: After the funeral	Certification;								· injury occurre	•			
Division of Vital Records,	I or Attendate death Director:	iffice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 288. Place	e of Injury - At hom	ne, farm, stre	eet, factory, office		28f		eet and Number	or Rura	l Route Num	ıber,
	s afte ei Dir	Sert	4 Homicide	build	ling, etc. (Specify)					City or Town,	State)			
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the b	e best of my know pasis of examination	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date and pinion, deat	d place, and h occurred	I due to the cau at the time, dat	use(s) and man le and place, ar	ner as st id due to	ated. the cause(s	s)
	To the within 2 To the complet	×	29b. Signature and title of certifier				29c. License	number		29	d. Date signed	(Month, I	Day, Year)	
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	d		30. Name and address of person w	ho completed cay:	se of death (Item 2	23a) (Type, I	Print)	,, , ,			1.3/	- /		
	\mathcal{V}		Dute et Sin	4L5 cdl	4 208	Cre	un Hiel	wouse	Sw	alen	118/ Bun	w	MD 3	4061
	Sta		31. Date filed (Month, Day, Year)	32. F	4 20 S Registrar's Signatu	ire .	, (
3	Registra	all	MAY 25 2010	Lengue	D 14. 14	Jacke								

	Physician /Medical Examiner
- E	Funeral Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Yem 27 is marked other than "natural" or items 23a or 28a-f show ither traumatic event, the Medical Examiner must ha materia. permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau

Maryland 21215-0036

Baltimore,

Physician /Medical Examiner

burial-tran physician peen certificate this funeral After t

Division or Vital Records, P.O. Box 68760,

for director, page 2 s Hospital or Attending after death. filled in by 24 hours a within 2

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year DEWCA AM ANNA MAY 6:30 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7922 PHILADELPHIA ROAD ROSEDALE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 20 / 1924 9. Birthplace (State or Foreign Months Min. Days Hours 217 18 0127 1 □ M 2 🔀 F MARYLAND 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7922 PHILADELPHIA ROAD 21237 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: SpecifyHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ESSEX COMMUNITY Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAL COLLEGE 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** SVASEK FRANCES (unk) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY GREEN/DAUGHTER 7922 PHILADELPHIA RD ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 5/25/10 BALTIMORE, MD 21. Sign wife of Fund of Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARRHYTHMIA disease or condition resulting in death) OMINUTES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION ARTHRITI 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62032 M44 24 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JENNIFER HAYASHI 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2010 21 4:10 A.M May Captain Emanuele Lorenzo DiCasagrande Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Upper Chesapeake Medical Center Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) OV. 16, 1940 1 XM 2 □ F Country) **Director** 095-58-0429 69 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2X No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 3007 Whitefield Road 21028 USA 21215-0036 TU Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 'natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ within permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Sea Captain Shipping Be Maryland (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Niccolo Angelo DiCasagrande Chiara (unk) Bergamaschi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Whitefield Road, Churchville, Maryland 21028 Mirella DiCasagrande / Wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery : 5/24/2010 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fu al Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 problications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List on Onset and Death Immediate Cause (Final ev cinoma Priysician/ avyns 80 disease or condition resulting in death) 4 2an Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be かるOOなうえいるリー Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23h. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month g Unknown Part II. **Other_significant conditions** contributing to **peath but not** resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autoosy Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ၉ 1 Napatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/21/2010 Michendu Veducine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 500 CHESAPEAKE DR BEL AIR MO 21014 NNENNA UCHENDU 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

W

asagrand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** OLAF DEMPSEY 20° 20¶ื 5:37 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MANOR CARE-ROSSVILLE ROSEDALE If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 → M 2 □ F 88 Director 213-16-0959 MD SEPT. 18,1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sht: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examinar to ust be notified at 10d. Inside City Limits ROSEDALE BALTIMORE MD 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21237 6600 RIDGE RD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates: þ 1 ☐ Yes 2 🗓 No 3 Widowed 4 □ Divorced Completed marked other than "nature matter matter matter matter and matter and matter matter matter and matte 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL MOTORS CLERICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN E. DEMPSEY LILLIE MAY MOLESWORTH ဂ 19a. Informant's Name/Relationship (Type. Print)GUARDIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau J. MICHAEL HOLLOWAY-OF PROPERTY BALTIMORE, MD 21202 10 N. CALVERT ST SUITE 200 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/10 OAKLAWN CEMETERY BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enjer the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show heart failbre, ist only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month signed by the a Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 1 □Yes 21 1 ☐ Yes Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 1No funeral dir ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

St. 204 8813 Wordman Woods Road M1 121234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Davidson Jr. Month Day Year William John May 2010 46 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Towson Gilchrist Hospice 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months 1 🔀 M 2 🗆 F 213-40-0153 68 01/06/1942 Yrs MD **Director** Usual Residence of Decedent 10a. State MD 28a-f shov Anne Arundel 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie 1 ☐ Yes 2X No 10f. Zip Code 21060 10e. Street and Number 10g. Citizen of What Country? 108 Hollywood Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No USAF Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1959-79 White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Enterntainment 12 Be 17. Father's Name (First, Middle, Last)
John William Davidson Sr. 18. Mother's Name (First, Middle, Majden Surname)
Rosie Lee Ott ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Hollywood Drive, Glen Burnie, MD 21060 Son Anthony H. Davidson / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of once, cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State 5/26/10 Woodbine, MD Final Journey Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Leaves Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ cance disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Dav ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Y Other (Specify) Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760 Director: After this certificate has the Hospital or Attending Physician: The upleted filled in by the funeral director, within 24 hours after death.

To the Funeral Director: A

State

31. Date filed (Month, Day Registrar DHMH 17 Rev 7/2009

Medical

4 Homicide

MEUSSA

3 29b. Signature and title of certifier

29a. Certifier

determined

KUSSA J. Wolf

32. Reg strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

6701 N. CHARLES St.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

R125973

9d. Date signed (Month, Day, Year)

29c. License number

ODICINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 <u>George K. Eichelman</u> May 11:35a ^M **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Elizabeth Nursing Home Baltimore If Unde 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Hours Min Jan. 17, 1929 213-30-9598 Maryland Director 81 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature". ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Catonsville 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 Park Grove Avenue 21228 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Used Auto Parts Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George F. Eichelman Hilda Bellhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Anne Eichelman/ Wife Park Grove Avenue, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Marriottsville, Maryland Crest Lawn Memorial Cardens 5/25/2010 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner nma frank, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year the s ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has page 2 autons death? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ည 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

D34951

29d. Date signed (Month, Day, Year)

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		l- For State Registrar	Cert	ificate of	Death				Reg. No	1 m		621
Physicia cal Exami	an/	1. Decedent's Name (First, Middle,Last) Kyle Ferguson						2. Date of D Month May 19,	Day	Year		ne of Death 950 hrs
		4a. Facility Name (if not institution, give street and number)				tion of Deat		4	c. County of D		
		328 Prince George Street					aure1	- la Data of		Prince Geo	•	o (State or
Funeral Director		5. Social Security Number 6. Sex 7. As 1 X M 2 F	ge (în yrs. las	73 Yrs.	If Under Months		Under 24Hrs dours Mir	Sept.	17.	1936	oreign (M) Country)	(State or ISSOUTI
		Usual Residence of Decedent						1555			1401	
ow any		10a. State 10b. County	10c. City, 1	own or Location Laur								Inside City Limit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland Prince Georges 10e. Street and Number			10f, Zip Co	ode		-	10g. Cit	tizen of What	Country?	
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ician dical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line	I the death. [o not enter the	e mode of c	lying, such	as cardiac o	or respiratory a	arrest, sh	ock, or heart		roximate Interva ween Onset and Death
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nding i	ian/	3b. Was decedent pregnant in the past 12 months?	time of deat		al death er (Specify		ctopic pregna	ancy		Month	Day	Year
the atte	nysic	1 Yes 2 No 9 Unknown 9 Unknown		3 Otti	er (opean)							
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	by P	Part II. Other significant conditions contributing to deat		ulting in the un	nderlying ca	use given	in Part I.		_	use contribute		use of death?
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has be	Completed		-					aut per	opsy formed?	prior deat	to complet h?	tion of cause of
tificate or, page		25. Was case referred to medical			26.	Place of De	eath (Check	only one)	2 N	1 🗸	Yes	2 No
After this certificate funeral director, page	o Be	examiner?	ent 2 E	R/Outpatient		Othor			Reside	ence 6 🗸 O	ther: Scen	9
After t uneral	-	27. Manner of Death 28a. Date of Inju (Month, Day,)	ry 2 (ear)	28b. Time of Inj	jury 28c	. Injury at \		28d. Describ	e how inj	ury occurred	·	
Funeral Director: stely filled in by the f	Certification:	2 Accident Investigation			1	Yes 2		206 Lagation	(Ctanata	and Number of	- Pural Pa	ite Number, City
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Funers tely fill		29a. Certifier (Check only 1 Certifying Physician: To the best of m										
within 24 nours after death. To the Funeral Director: A completely filled in by the fi	Medical	one) 2 Medical Examiner: On the basis of exa and manner stated.	mination and	l/or investigatio				at the time, dat				
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		30. Name and address of person who completed cause of o	footh (least	33)		. O.IVI. E.			IVIA	, 20, 2010		
	- [Russell Alexander MD. Assistant Medic			Penn Str	eet. Balt	imore, M	D 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 20b.c per fh 9904 6-2-10 yt State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 May telina Frances Estelina Francis 7:25 Q M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lanham PG Doctor's Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

Jamaica **Funeral** 8. Date of Birth MAy 26, 1939 1 🗆 M 2 🖾 F Months Days Hours Min Director 70 Yrs. 225<u>-78-628</u>3 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD PG 1 Yes 2 No Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4302 Crelin Pl. 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Blackfighite, etc. Armed Forces?
1 ☐ Yes 2 ☐ No Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced If Yes, Give Specify: Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Suburban Hospital Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ isadora Jackson Andrew Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 Crelin Pl. Lanham, MD 20706 Yvonne Jackson/Sister 6-5- Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mdcem Nate Trains of Weinlace) Pk 4 ☐ Donation 5 ☐ Other (Specify) 21. Si Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral HM 0583 MiddlePort Ln White Plains MD 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last s a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policies, death. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis Suite 3 Bladensburg 31. Date filed (Month, Day, Year) State strar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month enda /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ierrace Day Bowle Prince Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min -66-1005 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic event, "Ite "Marical Evancina must be notified once." 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 res 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10406 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) onsul 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Mar ဂ္ 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code)
Bowle Maryl 10406 Terrace 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State place) 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service License 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Months Immediate Cause (Final **Physician** Metastatic uterine disease or condition resulting in death) leromyo sarcomo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been się , page 2 should b 1 ☐ Yes 2 🗗 🙌 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 **X**No 2 **ZI**No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Tes 2 € No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Nesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier completely (Check only within 2 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Orleans

1650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Am strong

31. Date filed (Month, Day, Year)

36986

Rm. 190

Baltimore MD 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Year **Physician** 12-05 AM LOSEPH 22 2010 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 05 MIC 8. Date of Birth (Month, Day, Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Min 1 3 M 2 □ F 9 217-38-7262 Usual Residence of Decedent Director ary ada 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exactions and be realthed at 1 Yes 2 □ No Director TIMOY 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced lac Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 above v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 1908 UMMUE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lopinson -ord wood obeyta Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, or Town. State Date 20c. Location 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-2010 21. Signature of Funeral Service License ·a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STACLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence off if any, leaving to minieute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No P.O. 9 Ulnknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð ficate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed NCEPHALO PATHY 24a. Was an 24b. Were autopsy findings available prior to completion of death? performed certificate 2 No 1 ☐ Yes 2 NO 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 5 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA po ce Certification: To this After thi 27. Manuer of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? . ∠ Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 285 SUDDI mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 283 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Betty 2010 5:59 Gadow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Con If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XXF Months Days Hours Min. (Month, Day, Year, Country) 61 **Director** NOV 29, 1949 <u>214-50-6166</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes XX No **TALBOT** MD **EASTON** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö "natural", or items 23a or edical Examiner must be Funeral 7296 FRANCIS ST. 21601 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2xx Married Maryland 21215-0036 1 Yes 2 XXNo Specify: WHITE If Yes, Give Specify: Completed 3 Divorced 4 Divorced Year or Dates and Mental Hygiene.

is marked other than "natur raumatic event, the Medical ! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) within " Elementary/Seconday (0-12) College (1-4 or 5+) STAFF **AUTOMOTIVE** permit. Page 1 and 2 should be med wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ JOSEPH DANIEL HURD GRACE ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND MICHAEL J. GADOW 7296 FRANCIS ST., EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (S GLEN HAVEN CEMETERY MAY 17, 2010 GLEN BURNIE, MD of Funeral Service 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. PINK M01148 426 CRAIN HWY CLEN BURNLE 23a. Part 1 dis nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death heart ailure Li Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical Due to (or as a consequence of) Examiner Diabeties Hellita Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and ruse as the burial-transit Pneumonia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 🗌 Unknown g 🗍 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

5

Raleena Bacchus, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOT#

29d. Date signed (Month, Day, Year)

May 12, 2010

29c. License number

1336374321

South Greene Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 2010 8:57AM Physician/ HON Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 8. Date of Birth Funeral Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matic event, the Medical Examiner must be notified at once. 10b. County Director 1 ♣Yes 2 ☐ No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. Specify: Baltimore, Maryland 21215-0036 Black 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Package In abore Be r's Name (First, Middle, Maiden Surname) 18 Mothe 17. Father's Name (First, Middle, Last) ပ Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or 19a. Informant's Name/Relationship (Type, Print) ughter Baltimore 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison torest 21. Signature of Funeral Service 621229 23a. Part 1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS PSI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 2 DAYS Examiner FOMON Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician that the death certificate be 68760 use as 23d. Date of delivery 23b. Was decedent pregnant Day Box in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown P.O. n signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No To the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perforn within 24 hours after death.

To the Funeral Director; After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 1 Natural 5 Pending 2 No 1 Yes Accident Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check 3 🗖 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 stame and address of person who completed cause of death (Item 23a) (Type, Print) CONT BALTIMORE SLAIB 31. Date filed (Month, Day, Year) 32. Reaskar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Betty Marie Groomes /Medical 4a Facility Name (If not institution, give street and number) Examiner **Funeral** Director Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

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Marital Status		12	2. Was Dec		er in U.	S.	13. Wa	s Deced	ent of I	lispanic	Origin? (Specify	Yes or No	0-			rican India	n,
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3 ☐ Widowed			If Yes, Gi Year or D				1 ∟	Yes 2	2 X No	Speci	fy:				Specify	c W	hite	
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17. Father's Name	(First, Middle,	Last)								18. Mo	ther's Na	ame (Fi	rst, Middle	, Maider	Surnam	1e)		
Willi	am Fo	ltz								M	lari	e M	lenn:	inge	er			
19a. Informant's Na			Print)			10h N	failing f	Addross	(Street	and Nun	nhar ar E	Dural D	auto Numi	har City	or Town	State	Zin Code)	21234
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20a. Method of Dis _! 1 □ &Burial 2 أ		3 □ Re	moval from	State	l c	emetery.	cremat	orv or of	her pla	ce)	N/		2010			-		
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21. Signature of Fu	neral Service	Licensee	104	. //			Eva	ans i	Fune	ess of Face	Chai	pel	and .	Çrem	atio	n Se	ervice	es
Cons	ne i	√. 1	V(= 70	200	·-										Mary.	Land	2123	
23a. Part 1. Enter t shock, or hea	rt failure. List	only one	cause on e	caused to each line	ne deati	n. Do no					as cardia	ac or re	spiratory a	arrest,				Between and Death
Immediate Cause disease or condition			mul	tio	rac	l N	Fa	ila	V C	_							01.000	and Down
resulting in death)			M U	(or as a	consequ	uence of)	:											
0		h	S	e Ps	is													
Sequentially list con if any, leading to im	mediate	, "	Due to	(or as a	conseq	uence of)	:											
cause. Enter Unde Cause (Disease or that initiated events	injury		abd	0 m	inc	21	00	rTI	\subset	an	eur	Ys.	M					
resulting in death)	Last	Ü.		(or as a												\neg		
		u.																
IF FEMALE:		23	c. If yes, ou	itcome of	nreans	ancv									00 D			
23b. Was deceden in the past 12			1 Live	birth 2	Feta	l death		ctopic p							23d. Da	te ot dei onth	Day	Year
1 ☐ Yes 2 ☐ 9 ☐ Unknown	₹No		4 ☐ Preg 9 ☐ Unki		ime or c	ieath	5 LI O	ther (sp	ecity) _									
						142- 21-41							00= Did	401-000		wiles de de	the serves	of dooth?
Part II. Other signif	icant conditi	ons contr	ibuting to a	leath but	not resi	uiting in t	ne unde	eriying ca	ause giv	en in Pai	rt I.		23e. Dia	topacco	use com	ribute to	the cause	or death?
· · · · · · · · · · · · · · · · · · ·												-	1 🗆	Yes 2	. □ No	3□ Pr	robably 4	Onknown
													24a. Was		24b.	Were au	itopsy findi	ngs available
												-		ormed?	.	death?		of cause of
25. Was case refer	red to modice	1								00.5		- 11 (5	1 ☐ Yes	2 110	0	1 ∐ Yes	2 🗆 No	
examiner?		_	spital:		=				. Oth	or:			heck only					
1 Yes 2			1 💆	Inpatien	_	ER/Outp 28b. Tir			^	4 🗆	Nursing		5 ☐ Res				cify)	
27. Manner of Deat 1 Natural	5 Pendir	ng	28a. Date (Mor	of injury oth, Day,	Year)	28b. Tir Inji	ıry		8c. Inju Woi	k?		28d.	Describe	now inju	ry occur	ea		
2 Accident	investi 6 □ Could	gation						M		Yes 2	∐No							
3 ☐ Suicide 4 ☐ Homicide	detern		28e. Place build	e of Injury	y - At ho (Specif	ome, farm	n, street	, factory,	office			28f.	Location City or To	(Street a	nd Numb e)	er or Ru	ural Route	Number,

2. Date of Death Month

Day

2010

00 4 3 AM

To the Hospital or Attending Physician: The law requires that the death certificate be execut Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun

12

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KoTTaraThil 9000 FRANKLIN Square DR Balto Md 21237 32. Registrar's Signature

To Houritail

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

MAY, 21,2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21 Physician/ 2010 Elizabeth M. Grove 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6109 Marietta Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Yea July 15, 19 1 □ M 2**X** F 96 212-14-9450 Director Maryland 1913 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director MD Baltimore 28a-f 1 X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 21214 U.S.A. 6109 Marietta Avenue items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Il Hygiene. Colf Course Elementary/Seconday (0-12) College (1-4 or 5+) Cashier other traumatic event. Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward C. Griffin Elizabeth A. Brenice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 110 Bell Court, Rotonda West, FL 33947 Wallace Eddleman/ Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State 05/24/10 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. Signature of Funeral Service Licenses Name and Address of Facility ans Funeral Chapel & Cremation Services 00 Harford Road, Parkville, Maryland 21234 / 3a. Purt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardia Im Jediate Cause (Final Ph sician/ uis ase or condition sulting in death) Medical **Examiner** Sequentially list conditions, Due to lor as a consequence of if y leading a immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? completed filled in by the funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 💆 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 5 \square Pending Natural 2 🗌 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the i only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 038098 2010

State Registrar

31. Date filed (Month, Day, Year) **HAY 25 2010**

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Goldman, M.D. 9106Philadelphia Road, Suite 304, Rosedale, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Gutman Physician/ 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COLUMBIA 5400 VANTAGE POINT ROAD, #104 Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth **Funeral** 12710719 1 □ M 2 🗓 F Months 90 Director 146-18-5938 Usual Residence of Decedent ural", or items 23a or 28a-f sho I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director COLUMBIA MD HOWARD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 21044 5400 VANTAGE POINT ROAD, #104 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 WHITE 1 ☐ Yes 2XXNo Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BINSWANGER ALBERT **ABRAMS** SARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5458 BLUECOAT LANE, COLUMBIA, MD 21045 LOIS GUTMAN/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place BALTIMORE HEBREW CEM. 05/23/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) Wrefof Funeral Service Mense 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final arryThoma Condiac Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 No Day Year Pregnant at time of death 9 Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hypatyro, desin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 **N**0 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of pertifier cause of death (Item 23a) (Type, Print)
10 5005 Signal Bell lane Clarlisull MD 21029

Registrar

				Please	Type or Pri							0010	
			For State		State of M	aryland	•	artment of I		nd Mental	Hygien	e2011) 6228
			Registrar	je (First, Middle, La:	st)		Cei	tificate of l	Jeath	2. Date o	Reg. I		3. Time of Death
5	Physic Me	cian/ dical	N	ERL	IN J	Toh	N	Higg	INS	Month	ا ب	20 20 Year	1111
17243	Exan		4a. Facility Name (i	f not institution, give	e street and number)	60	Î	4b. City, Town, o	r Location of	Death		c. County of Dea	th
200	Funer		5. Social Security N		ex 7. Ag	e (In yrs. las	_	If Under 1 Year Months Days	If Under 2		f Birth	9. Bin	rthplace (State or Foreign
S	Direct		215-54 Usual Residence o	1-0106	W 2 - 1	59	9 Yrs.			Se	, Day, Year p 15	, 19 5 0 1	North Carolin
2	ryland F shor	ļģ.	10a. State	10b. County	,		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛂 No
8	he Ma or 28a e notif	Director	10e. Street and Nu	Harfo	ora	<u> </u>	Darlin	10f. Zip Code			10a.	Citizen of What Co	
410	s 23a nust b	Funeral	1621 0	astleton	Road			210	34			United	States
	r death r item iner m	- Fur							lispanic Origir an, Mexican,	n? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ame Black, Whit	
	0036 Irs after Iral", o	ed by	3 Widowed		If Yes, Give Year or Dates.	196	0	I ☐ Yes 2 █★No	Specify:			Specify:	White
	15-C 72 hou n "natu ledica"	Completed	(Spe	15. Decedent's E ecify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Occup kind of work done O NOT use retired)	during most c	of working	16b.	Kind of Business	Industry
	212 within giene. er tha	ပိ	Elementary/Sec 12	onday (0-12)	College (1-4 or 5	5+)		inter				Commerc	ial Painting
	Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle, Last) Charles Higgins, Jr 18. Mother's Name (First, Middle, Maiden S Ruth Leona Mc'Neil							·			
				ame/Relationship (7 Higgins	,, , ,			ng Address (Street 521 Castl					
0	Baltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or othe	6			Removal from State	, ce	metery, cren	sition (Name of natory or other place ake Cren		Date May 2010	22 , ^{20c.}	Location - City or Beltsvil	Town, State
3	Salti ermit. F epartm nporta ny inju	90		neral Service Licen		0144		. Nam e and mach				natives	
5	m 00 = 0	0	23a Part 1 Edter	the disease or com	plications that caused	the death	Do not ente					wson Mary	yland 21286 Approximate
2,5	Physicia	1/	shock, or hea Immediate Cause disease or condition	rt failure. List only o (Final	one cause on each line	e.) (7	.g, 00011 00 00	aroug or roop acc	y uncon		Interval Between Onset and Death
	Medic Examin	al	resulting in death)	" <i>(</i>	a. Due to (or as	a conseque	ence of):	× 4.					
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47	e executed vian and urial-transit	Examiner	if any, leading to in cauce Enter under Cause (Disease or that initiated even	iinjury	С								
7314	e exec ician ar ourial-t	<u> [</u>	resulting in death)	Last	Due to (or as	a conseque	ence of):						
8	68760 certificate be nding physic use as the bi	¶edic			d								,
_	Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknowr	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	ру		-	23d. Date of de Month	livery Day Year
NS	P.O. that the ned by e detacl				ontributing to death b	out not resul	Iting in the u	nderlying cause gi	ven in Part I.	23e. [id tobacco	use contribute to	the cause of death?
	ds, I quires 1 en sign	ted b								1	☐ Yes	2 □ No 3 🔀	robably 4 🗆 Unknown
119	Records, The law requires ate has been sig	Completed by				_				a	Vas an utopsy erformed?	prior to	topsy findings available completion of cause of
	I Re in: The ifficate or, pag		25. Was case refer					26 P	ace of Death		es 2		s 22 No
	of Vital ig Physician: ter this certific	To Be	examiner?	□No	Hospital:	ent 2	R/Outpatier	nt 3 🗆 DOA Oth	er.	sing Home 5 🗆 F	Residence	6 ☐ Other (Spec	cify)
77	n of Jing Pl After th		27. Manner of Deat	5 Pending	28a. Date of inju (Month, Day	iry y, Year)	28b. Time of injury	work			be how inj	ury occurred	
کے	Division tal or Attendir s after death. al Director: Af	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inju		ne, farm, stre	M 1 L	res 2 🗆 N	28f. Locati			ral Route Number,
Merur	Division of Vital Recc To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical Co	29a. Certifier	Certifying Phy	building, etc	ny knowle	dge, death o	occured at the time	, date and pla	ace, and due to th	Town, Sta	and manner as st	ated.
	the Ho nin 24 l the Fu npleted	Med	only one)	Certifying Nur	iner: On the basis of e se Practioner: To the	amination a best of my	and/or invest knowledge, o	igation, in my opinion	on, death occu e time, date a	urred at the time, d nd place, and due	ate and place to the cause	ce, and due to the e(s) and manner as	cause(s) and manner stated. stated.
4	o Sitting Sit		29b. Signature and title of certifier 7 29d. Date signed (Month, Day, Year) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										h, Day, Year)
	14/		Nonald	VanWi	completed cause of d	eath (Item 2	23a) (Type, P	Print)	peak	e Dr. L	3el	Aic. MI	21014
	S Regis	tate trar	31. Date filed (Mon	25 2010	32. Registra	ar's Signatu	bark	,	1			. ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician STEWART 20 2010 9-00A M HANN MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Lorien Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | May 24, 1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**K**F Yrs New Jersev 92 141-03-2953 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Columbia Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 U.S.A. 10820 Symphony Way Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Taryes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Aeronautical Engineer **AeroNautics** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Unknown Stewart Jacob Hann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1046 Ransom Road Grand Island, New York 14072 (Daughter) Susan Hann-Sica 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Cemetery 5-27-2010 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045 21. Signature of Funeral Service Ligenses Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INSUFFICIENCY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): ASPIRATION Examiner NEUMONIA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner DYS PHAGIA that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ARTERY 1 Yes 2 No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: yperlende 1□ Yes 2□Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

9650 Senhap

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

akunmale

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hal 9:04pm 5 2010 Howard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carro my OVE House Jesminter If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6/3/1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 X M 2 □ F 79 Director 212-24-6489 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evan the coust by myllhed at 10a. State 1 □Yes XIXNo Director Woodbine MD Carroll the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21797 USA 7724 Morgan Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1947-51 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LPN Springfield Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Belle Hatfield ဂ္ Ernest Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other troonce. Audrey Ann Hall/Wife 7724 Morgan Rd., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Poplar Springs Cemetery 5/26/2010 Poplar Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Firt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on se on each line. Approximate Interval Between Onset and Death Immediat - Cause (Final distance or condition resulting in death) Physician | 4/01/10+05/24/0 ancer Ver /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 No 2 440 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural To the master death.
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 🗓 😅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00064597 Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET WESTMUNSPER ENTER 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 26 per pHYS, G903, 5/25/2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **EUGENE** Physician/ **EDWARD HESS** . Day 201 Ö ear MAY 20, 1:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 829 CHESACO AVENUE ROSEDALE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**火** M 2 □ F 65 Months Days Hours Min. VIRGINIA 232-72-9298 **Director** W. 9-20-1944 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 829 CHESACO AVENUE 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 72 hours after δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+ TRUCK DRIVER SEAL TEST KRAFT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EUGENE P. **HESS** EDITH Ρ. (IMES) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MARY JOETTE HESS/WIFE ROSEDALE, 829 CHESACO AVENUE MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State HOLLY HILL MEM. 5-24-10 MIDDLE RIVER, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUN 1211 CHESACO AVENUE ROSEDALE, 21. Signature of Funeral Service Licenses HOME 21237 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metasta Physician/ arcinomo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, the sequential cause. Enter Underlying Cause (Disease or linjury that initiated events Disk to (or as a nonsequence of) Exami and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No ed by the 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Jas autopsy prior to completion of cause of death? page certificate I Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: Inpatient 2 ER/Outpatient 3 DOA ပ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending thin 24 hours after death the Funeral Director: A mpleted filled in by the fi after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 2 0 29d. Date signed (Month, Day, Year) D0056919 MAY 21, 2010 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 SUITE 205 BALTIMORE, MD ROBERT DONEGAN 6569 N. CHARLES STREET 32. Registrar's Signatu State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death мАЧ 24, 2010 Physician/ HUMPHREY 5:30 ам STEVEN ERIC Medical 4c. County of Death
BALTIMORE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ROSEDALE 6005 SHADY SPRING AVENUE 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 215-13-7492 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) 5 1 XM 2 □ F Months Hours MARYLAND Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location with the Maryland Examiner must be notified at Director BALTIMORE ROSEDALE MD 1 Yes 2 Wo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21237 6005 SHADY SPRING AVENUE items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married "natural", or ð Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: WHITE Specify 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) le 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) SELF EMPLOYED CARPENTER Be 18. Mother's Name *(First, Middle, Maiden Surname)* DOROTHY (DelBROCCO) 17. Father's Name (First, Middle, Last) ၉ **ARTHUR** STEVEN HUMPHREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $6\,0\,0\,5$ SHADY SPRING AVE ROSEDALE, MD 21237 DOROTHY HUMPHREY/MOTHER permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 5/28/10 BROOKLYN, MD CEDAR HILL CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee CHESACO AVE ROSEDALE, 21237 1211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death signed by the a Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag. 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 1 မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 STANLEY WALKER 711 W. 40th 21211 STREET HAMPDEN, MD 31. Date filed (Month, Day, Year) **4AY 25 2010** 32. Registrar's Signatur State Registrar

10-03730 Alvin Holmes, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	Ce	ertificate	of Death		R	eg. No.	
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	I - 1				Date of Dea Month	Day Year	3. Time of Death 1001 hrs
Wedical Examin	ner	Alvin H	lolmes		4b. City, Town, o	or Location of	May 15, 2	4c. County of D	
		Johns Hopkins Hospital	,		Baltimore			NA	
Funeral		Social Security Number 6. Sex	7. Age (In yrs	last birthday	· — —				J. Birthplace (State or oreign
Director		217-66-5559 12M	2 F 54		Yrs. Months Da	ys Hours	Min. 05-24	- 55	Country) MD
y	Ī	Usual Residence of Decedent 10a. State 10b. County	I10c Cit	ty. Town or Lo	ocation				10d. Inside City Limits
OW at				altimo					1X XYes 2 No
rrylanc	ctor	MD NA 10e. Street and Number	D3	altimo	10f. Zip Code		1	0g. Citizen of What	Country?
he Ma 1 or 28	Director	517 N. Decker	Avenue		2122	24		USA	
with 1		11. Marital Status	2. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Orig	gin? (Specify Yes or No	- 14. Race - A	merican Indian, Black,
death or iter	Funeral		Armed Forces? Yes 2 X No				, Puerto Rican, etc.)		tc. African
s after iral", niner	à	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:	160 0000	Yes 2 A N	o specify:	kind of work done	Specify: A	merican
2 hous	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		g most of working lif			TOD. KING OF BUSIN	ess/maustry
036 ithin 7 ne.	힕	7th Grade	NA	La	aborer			self-e	mployed
5-0 iled w Hygie I other		17. Father's Name (First, Middle, Last)		•			's Name (First, Middle, N		
121 d be f fental sarked event,	o Be	Schanzas A. 19a. Informant's Name/Relationship (Type	Holmes	10b Ma	iling Address (Stee		y G. Cald		State Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۲	Alicia Holmes-D	•				rt Baltim		21202
e, N I and I Health item I	ı	20a. Method of Disposition	206	o. Place of Dis	position (Name of c		Date		ty or Town, State MD
MOF ages ant of a		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	Cedar	rotherplace) Hill Ce	em.	05-22-10	Anne A	rundel Co,
altir mit. I partmo ports:	ı	21. Signature of Euneral Survice Licensee	0.	2	2. Name and Addres	ss of Facility	′ Wylie Fu	neral H	ome P.A.
		Mo My	l		638 N. G	Gilmo	r Street	Baltimo	re, MD 21217
Physician /M di_al		23a. Part 1. Enter the disease, or complicate failure. List only one cause on each I	ine.						Approximate Interval Between Onset and Death
Examiner	ĺ		structive pu				plicated by	narcotic	Death
		Sequentially list conditions, b	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, and	Cocarne				
	Medical Examiner	if any, leading to immediate but cause. Enter Underlying Cause	to (or as a consequence	Of J:					2
J	xam	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence	of):					
3760, ficate be executed g physician and s the burial - transit	ia E	d							
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1876 rtificat ing ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre	egnancy 2	Fetal death 3	Ectopic	pregnancy	Month 23d. Date of de	Day Year
OX 6	Physician/	1 Yes 2 No 9 Unknown	Pregnant at time of o	death 5	Other (Specify)				
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certifit ars after death. 14 Director: After this certificate has been signed by the attending, lied in by the funeral director, page 2 should be detached for use as it.	F.	Part II. Other significant conditions col		t resulting in th	ne underlying cause	given in Pa	rt I. 23e. Did to	bacco use contribut	e to the cause of death?
P.C es that	d by						1 Yes	2 No 3	Probabiy 4 🗸 Unknown
rds requir	Completed	,					24a. Was autop		e autopsy findings available r to completion of cause of
eco he law ate has	E O						perfor	med? dear	
al R ian: T certific ctor, p	a l	25. Was case referred to medical examiner?			26.Plac	-	(Check only one)		
With Spice of this of all dire	P P	1 Yes 2 No	I Inpatient 2 V					Residence 6 0	Other:
n of oding landing lan	ë	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time		ury at Work Yes 2	ı	now injury occurred	
isio Atten er deat rector by the	icati	2 Accident Investigation	28e. Place of Injury - At	home, farm, s	1-00-			Street and Number of	r Rural Route Number, City
Div ital or urs afte	Certification:	3 Suicide 6 Could not be determined	(Specify)				or Town, S		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as t		(Oncon only	To the best of my knowle	_					
To the within To the compl	Medical	and	the basis of examination manner stated	and/or invest			curred at the time, date :		
	2	29b. Signature and title of certifier				.M.E.		May 16, 2010	(Month, Day, Year)
	-	30. Name and address of person who com	pleted cause of death /Ite	om 23a)					
\emptyset			fedical Examiner		n Street, Baltim	ore, MD	21201		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	4				
Regist		MAY 2 5 2010 /2	was B.	parke					
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Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDWARD J. HEIDEL 8:06 nas 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE Age (In yrs. last birthday) 6. Sex 1 ØM 2 ☐ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 208-16-6309 Months Hours Min. 2477397925 PENNSYLVANIA Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD BALTIMORE PARKVILLE 28a-f 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Examiner must be Funeral 23a1811 WENDOVER ROAD 21234 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 🔀 Yes 2 🗌 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify; 3 Widowed 4 Divorced If Yes, Give "natural", Specify: WHITE Year or Dates. WWII other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) SHOP FOREMAN DEPT. OF ARMY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be FREDERICK HEIDEL JOSPEHINE KOTINSLEY and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau RITA M. HEIDEL/WIFE 1811 WENDOVER ROAD PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY INC. 5/25/2010 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Dun to for as a constituints of Exami resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ó Month Pregnant at time of death the 9 Unknown g 🗌 Unknown P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🔀 R/Outpatient 3 🗌 DOA ျ this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be the 1 4 Homicide l in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of p Maryland aven

DHMH 17 Rev 7/2009

State Registrar ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 ear Physician/ Month Day Theodore F. Jones 0755 24 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center 8. Date of Birth
(Month, Day, Yea
Jan. 15, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 T.T. 77 Funeral Year) 925 Days 1 🕽 🖈 M 2 🗆 F Hours 233-32-2829 85 Yrs WVA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Middle River Baltimore MD 1 🗌 Yes 2 ី No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21220 213 Glider Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Boeing Co. Aircraft 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary M. Cameron Willard F. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 Glider Drive Baltimore MD Peggy Geigan /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory of other place)
Bayview Crematory 5/25/10 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature f Funeral Service License 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each life. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between set and Death Immediate Cause (Final Physician/ lication disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentiary list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown nsons 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perforr 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2**X** No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 105) 1 C 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 - Pending work 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 6201

V. CHRILES J. BAKIMORE MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Ce	ertificate of D	eath	,,,	Reg. No.	
Physici Medical Exami	an/	1. Decedent's Name (First, Middle	Jones			2. Date of De Month May 19,	Day Year 2010	3. Time of Death 1022 hrs
		4a. Fácilify Namé (if no institution 500 Virginia Avenue		Т	City, Town, or Location of I OWSON	Death	4c. County of Dea Baltimore Co	
Funeral Director			6. Sex 7. Age (In yrs	• • • •	Months Days Hours	Min. 8. Date of E	9. Birth(MM/DD/YYYY) 9. B 4-1974 C	
Maryland 28a-f show any d at once.	o	10a. State 10b. County MD Bal-	timore T	by, Town or Location	n			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	1 Director	10e. Street and Number	a Ave Apr	1-402 1°	f. Zip Code 21 286	,	10g. Citizen of What Co	untry?
r death w or items must be	by Funeral		rced If Yes, Give Year or Dates		ecedent of Hispanic Origin specify Cuban, Mexican, P s 2 No s <i>pecify:</i>		14. Race - Ame White, etc. Specify: B	erican Indian, Black,
136 thin 72 hours reserved than "nature edical Exami	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12)	fy only highest grade completed) College (1-4 or 5+)	during most of	Isual Occupation (Give kin of working life, DO NOT us		16b. Kind of Business	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, I	Jones			Name (First, Middle,	, Maiden Surname)	7.0.4
and and and and and and and and and and	P.	Michelle Gr 20a. Method of Disposition	Repa Aunt	8366 Place of Disposition crematory or other p	Govern (Name of cemetery,	or Rural Route Nu	Ison Lay	21043 Town, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other trau		4 Donation 6 Other Specification of Funeral of Ice L	ecify: K	ing Memor	and A diass	124/2012	Baltimo	re MI)
Physician Medical		23a. 17 rt I. Enter the disease, or callure. List only one cause of Immediate Cause (Final disease	n each line,		ode o dying, such as card	liac or respiratory ar	rrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence					
si d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence c. Due to (or as a consequence					
760,	Medical E	X UNPENDED	dAM5NDEPII,27,p	er ME g90.	5 7/22/10 TT	<u>.</u>		
Box 68760, e death certificate be the attending physicied for use as the burn	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unkr	4 Pregnant at time of d	2 Fetal de	eath 3 Ectopic pr	regnancy	23d. Date of delive Month	ry Day Year
hat the de led by the detached f		Part II. Other significant condition	ns contributing to death but not	resulting in the under	lying cause given in Part I		tobacco use contribute to	
rds, Prequires to been sign bould be o	eted t	Cerebral malfo	rmation				s an 24b. Were a	utopsy findings available
Division of Vital Records, P.O. Box 68' tal or Attending Physteian: The law requires that the death certifiers after death. 1at Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Completed by	25. Was case referred to medical			26.Place of Death (Ch	1 Yes	ormed? death?	completion of cause of
Vita nysician this cer	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Othor		Residence 6 🗸 Othe	er: Scene
ion of tending Pt eath. or: After the funeral	ation: T	27. Manner of Death 1 X Natural 5 Pendir 2 Accident Invest		28b. Time of Injury	28c. Injury at Work?		how injury occurred	
Divisior oital or Attend urs after death eral Director:	Certification:	3 Suicide 6 Could determ	not be 28e. Place of Injury - At I	home, farm, street, fa	ctory, office building, etc.	28f. Location (or Town,	(Street and Number or R State)	ural Route Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical ((sician: To the best of my knowled iner:On the basis of examination and manner stated.					
	Ž	29b. Signature and title of certifier	To Vell	1 4950	29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day,Year)
ϕ		30. Name and address of person w Victor Weedn MD JD	ho completed cause of death (Iter Assistant Medical Exam		Street, Baltimore, I	MD 21201		
St Regist		31. Date filed (Month, Day, Year) MAY 2.5. 2010	32. Registrar's Signal	ture harry				
DHMH 17 Rev 1/20 OCME 2006	_	0CM	E	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 11:43 PM Margaret Medical Agnes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Lutherville</u> Baltimore Stella Maris Hospice Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Hours Min 4/12/1925 Mary Land Director 85 213-20-2252 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1406 Franklin Avenue 21221 S. A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Francis Patrick Doherty Marie Eder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 1406 Franklin Avenue Essex Maryland 21221 Roman Krol 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Mem! Gard. Overlea, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski 1407 Old Ea Funeral Home Maryland .21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live Birth} \) 2 \(\subseteq \text{ Fetal death} \) 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 Tyes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 X certificate 1 ☐ Yes 2 ☐ No or Attending Physician: completed filled in by the funeral director, of Vital Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Inversing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar enCAN 2010 () s of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 2000 gistrar Signature

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day,

rack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Thomas Patrick Kappler Sr. 2010 12:00 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Savare segalt saltimore 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) Maryland Social Security Number Age (In yrs. last birthday) Days Year) 1⊠M 2□ F 214 14 4157 88 Dec.12, 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Middle River Baltimore 1 ☐ Yes 217 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 906 Frog Mortar Rd. 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 1⊠Yes 2 No If Yes, Give Year or Dates: 1942/45 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah O'Donnell William Kappler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 906 Frog Mortar Rd. Baltimore, Maryland 21220 Patricia McClure (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 5/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a Pgt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUH MOX+ 1/C

Due to (or as a consequence of): 10 Days Days neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEDSIS Days rere Due to (or as a consequence of): Fibrilla hor Pays If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Olume Overload 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy 1 ☐ Yes 2 🖾 No 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner requires that the death certificate be executed and

Box 68760.

P.O. I

Records,

Division of Vital Hospital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemination ust be notified at

Aρρ\∢Υ, TYNVMA? Baltimore, Maryland 21215-0036

Examiner burial-trar physician Physician/Medical the attending asn for Completed director, page 2 should has certificate Be ဥ After this Certification:

25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

05,23,2010

29c. License number D0069447

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Drive Baltimore MD 21237 Dr. Kenneth Eaddy 9000 tranklin

31. Date filed (Month, Day, Year)

29a. Certifier

32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

State Registrar

24 hours after death. Funeral Director: A

within 2.

filled in by the

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Kenneth L. Kunkle 2010 May 10:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)PA. Days Min. 1 🖾 M 2 🗆 F Months Hours 1677271937 218-32-5508 Director 72 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD. Carroll Sykesville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21784 5907 Dale Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname)
Rose Bond 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta Important if feen 27 is marken any injury one. Carroll Kunkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Kunkle/Wife 5907 Dale Drive Sykesville, MD. 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodbine, MD. 05/22/2010 Ebenezer Cemetery Penation 5 Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road 21. Signa of Funeral Service Licensee & Crematory, Winfield, MD. nter the disease, or complication rheart failure. List only one car that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death ause (Final Onset and Dea iate OBSTRUCTIVE PULMOTARY Physician/ CHRONIL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 2 🛂 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 TNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Matural 5 \square Pending Accident 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year K. Galus in mo D31660 ramos 19/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5v

State Registrar TITOMAS K.

31. Date filed (Month

DHMH 17 Rev 7/2009

gistrar's Signature

STONER ANOUSE WESTMINISTER

MALLIAND 21157

X State Registrar

29b. Signature and title of certifier

MARGARET

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

Vital

3901

egistrar's Signature

29c. License number

THE PLAMEDA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Suzanne L. Khederian 21 2010 May 5:00A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Keswick Multi-Care Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 015-24-9290 1 □ M **X**□ F 101 France 26 1908 Director Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 Y Yes 2 □ No Director MD Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4100 N. Charles St. #903 21218 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: Specify: þ X□Widowed 4□Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) n/a Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Boucher Lucy Michaud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Devon Hill Rd. #A-6, Balto., MD 21210 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Ann Walsh/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buriat 2 ☐ Cremation 3 ☐ Removal from State 5/26/10 4 Donation 5 Dother (Specify) Garrison Forest, MD MD Vet. Cem. Garrison Forest Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21. Signature of Funeral Service Liber Michael 9. 23a. Part1. Enter the Asease, or come set shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final concestive **Physician** disease or condition resulting in death) /Medical Due to (or as a lonsequence of): Examine Jascular disease entensin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or + a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed lmona Division or Vital Records, P.O. Box 68760, $\!arphi$ attending physician and for use as the burial-tran Due to or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D006478 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST. SUITE 301 BALTIMOLE MD 21201 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per FH G903 5/2//10 11

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month Walter Elijah 18°, 2010° King Jr. 1:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 320 Highland Drive Apt. 202 Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Hours March I Days Min. 266-50-4766 Director 75 1935Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗀 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 320 Highland Drive Apt. 202 21061 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural" 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Electrical Engineer U.S. Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ရ Walter E. King Susie Mrs. Alma Elskoe Treing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pe 1 and 2 s t of Health a lf item 27 i Alma Elskoe/ Wife 100 Aldrich Street Apt 19F Bronx, NY 10475 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify Entombment Woodlawn Cemtery Bronx, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, NO:22 MD 21061 art 1. Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 100anan disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) MXIP Exam nding physician and use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy perform certificate 1 Yes 2 No 2 Yes of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide To the Hospital or Attending 5 Pending work' Division 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, gate and place, and gue to the cause(s) Certifying Nurse Practioner: no the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ May 20 2010 Demetrice Kellum 9:55 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 201 1st Avenue Baltimore Lansdowne Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Days Dec. 22, 1960 Months Hours Min. North Carolina **Director** 49 239-08-8772 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lansdowne 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 1st 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify: American Indian If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Completed 3 Divorced 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Production worker MD clothier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Steamon Harding Berlie Brewington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Kellum-husband Avenue, Lansdowne MD 21227 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Atlantic Crematory May 25,2010 Glen Burnie MD 4 Domation 5 Other (Specify) Ambrose Funeral Home of Lanslown 22. Name and Address of Facility 2719 Hammonds Ferry Road, Lansdowne MD 21227 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death S METASTATI Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform certificate 2 🗀 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ ER/Outpatient 3 DOA 1 Inpatient 2 I this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No hours after death. Investigation 6 Could not be within 24 hours after death

To the Funeral Director: / Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar AVE

BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ST AGNES

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, 20b, 22perFH, G903, 572572010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 06:25 M James Knight Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, NC Country) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F 69 Director 11-04-1940 242-54-2613 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PG Hyattsville X 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 20784 5504 Newton St. Apt. 7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes SpecifyBlack Baltimore Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) DISADIEO 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elnora Barnhill James Knight, Sr 19a, Informant's Name/Relationship (Type, Print) 5504 Newton Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 Newton Street Apt/ Hyattsville, MD. 20784 5504 Newton Apt7 Hyattsivlle, md 20784 Gloria Staton/Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale Park Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Funeral Service Licenty 21. Sig y y 23at Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death , or heart failure. List only one cause on each line. Immediate Cause (Final ENLEPHALOPHATHY Physician JIYONA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Rena1 Sequentially list conditions. Examine n any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to tor as a consequence of Seps:5 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Halpert en sion Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has k autopsy performed? death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**O ၀ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours : Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29c. License number D0059981 20 2010 muxemil Abdelus, mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mykemil Abd ella Bm, , 12200 Annapolis Rd., Suite 229, Glemn Dale, MD. 20169 31. Date filed (Month, Pay 2010 32. Registrar Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17 Physician/ 2010 2:30 A^{M} Elizabeth Lang Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice of Northwest Hospita Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 Months Days Hours Min. March Day Year 1920 West Virginia 234-16-9111 90 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 ☐ No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 U.S.A. 3722 Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School System Teacher/Coach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Edna Marquis Frederick Albert Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6259 Woodcress Dr., Ellicott City, MD Audra Cox (Great Niece) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill Cemetery 5-21-10 22. Name and Address of Facility Hastings Funeral Home, Inc. 153 Spruce St., Morgantown, Funeral Service Lices . Sig WV 26505 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ min disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death as been signed by the attending 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣️ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page performed certificate ! 25. Was case referred to medical 26. Place of Death (Check only one) Be funeral director, Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA ther (Specify) After this 27 Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 M Natural 5 Pending work To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

's Signature

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:16 AM Physician/ Month May 21, 2010 Lawrence Andrew Larsen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Age (In vrs. last birthday) Days Hours 1 🔀 M 2 🗆 F 71 Min May 05, 1939 ^CNorth Dakota 502-34-8458 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 United States 904 Sibley Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates. item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hopkins Homewood College (1-4-or 5+) Elementary/Seconday (0-12) Campus University Professor Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Bernard Larsen Florence Larsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Larsen /Wife 904 Sibley Rd. Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot May 22 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives MOVYY 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) mouth Medical Due to (or as a cons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled to the funeral Director. Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Tyes 2 🗀 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu title of certifier 29d. Date signed (Month, Day, Year) 2010

State Registrar 31. Date filed (Month, Day, MAY 25

TOWSON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

iks

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma	aryıanc	•	artment of I tificate of I				giene Reg. Na	2010	1624
	Physicia	n/	1. Decedent's Name Delma	(First, Middle, L Barbara	ast) Loss						2. Date of De.	ath		3. Time of Death 05:30 DM
	Medic Examin	al			ve street and number)			4b. City, Town, o		n of Death	1 kg 20,		c. County of Dea	
			5607 Pion 5. Social Security Nu			//	t binth doub	Bal If Under 1 Year	timore	er 24 Hrs.	O Data of Bio		N/A	44-1 (O4-4 C
	Funeral Director		212-30-2279		1 M 2 X F	(In yrs. las 76	Yrs.	Months Days	Hours	Min.	8. Date of Birl			thplace (State or Foreigr untry) MD
	and show fat	ō	Usual Residence of I 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation			10d. Inside City			
	e Maryl r 28a-f notifie	Director	MD_	N/A		Balt:	imore	T400 77 0 1			- 1			1 🔀 Yes 2 🗆 No
	with the 23a or	Funeral I	10e. Street and Num 5607 Pionee					10f. Zip Code 21214			ļ	10g. Ci U.S. <i>P</i>	tizen of What Co	ountry?
36	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items cevent, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Marrie	ed 2 🛛 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💢			Vas Decedent of H Yes, specify Cub			cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
9	hours a natural' ical Ex	leted	3 Widowed 4	15. Decedent's	Year or Dates. Education		16a. Deced	ent's Usual Occu	pation			16b. k	Specify: (ind of Business	White
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d 2	ld be filed within Mental Hygiene arked other th a atic event, the I	Ba	12 17. Father's Name (F	irst, Middle, Las	*)		nuile in	anei	18. Mot	her's Name	e (First, Middle,			
rylar	0 2 2 0	욘	John 19a. Informant's Na		Louis			ddry, Sr.		anora_				Born
, Ma	and 2 should Health and Me tem 27 is marl		George J. L					g Address (Street Pioneer D				-		o Code)
Baltimore, Maryland 21215-0036	Page 1 and 2 ment of Healt ant: If item 2 ury or other		20a. Method of Disp 1 X Burial 2	Cremation 3	☐ Removal from State	ce	metery, crem	sition (Name of natory or other pla	ce)		Date (COAC)		ocation - City or	
altin	permit. Page 1 and Department of Hamportant: If ite any injury or of once.		4 Donation 21. Signature of Fun			1 Garc	dens of	Faith Name and Addre Leonard J	ess of Faci	05/27		Bal	timore, M	arytano
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Division of Vital Records,	> 0 01	Completed	Bi	Dar	MNESS	4	<u></u>				24a. Was autor perfo		prior to death?	topsy findings available completion of cause of
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of V	ng Phys ter this neral di	te: To	27. Manner of Death	,	1 ∐ Inpatie 28a. Date of injur (Month, Day	у 2	R/Outpatien 28b. Time of injury	t 3 DOA 28c. Inju	4 <u> </u>		me 5 Residence 128d. Describe 1		Other (Spectory occurred	<u>:ify)</u>
sion	Attendir death. ctor: Af y the fu	Certificate:	Accident 3 Suicide 4 Homicide	Investigat	be 28e Place of Inju			M 1 🗆	Yes 2	_	28f. Location (S	Street an	nd Number or Ru	ral Route Number,
D.Y.	ital or / urs after ral Dire		r)	determine	building, etc				_		City or Tow	n, State		
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page?	Medical	(Check 2	Medical Exa	nysician: To the best of a miner: On the basis of exurse Practioner: To the l	kamination.	and/or invest	igation, in my opin	ion, death	occurred at	the time, date a	and place	e, and due to the	cause(s) and manner state
)	To the To the comp		29b. Signature and t	itle of certifier	Vala	0	MX	29c. Licens	se number	PD		29d. Da	ate signed (Monta	h, Day, Year)
			30 Name and addre	ss of person wh	completed cause of de	eath (Item 2	23a) (Type, P	rint) V 16	rel	Ro	√. ∧	<u>د</u> ۲ ۸	212	24
	Stat		31. Date filed (Month		32. Redistra	r's Signatu	ire A	Land		- 1	7 '		2100	
	Registra	ar		MAY 25	2010 Dens	un	13. 14	TALK ST						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2 nous 1600 HES 20 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Acence 1timon 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Hours Runtry) C . Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black White etc Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. (Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father 's Name (First, Middle, Last) 8. Mother's N me (First, Middle, Maide ည 19a. Informant's Nam / Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i other Method of Disposition Ob. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Part 1. Enter in discourt, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter f e mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death meast Physician/ Metastatic cancor years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Deenen tree 2 No 3 Probably 4 Unknown Certificate: To Be Completed 1 🗌 Yes Embal, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 D Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058893 24 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ø Browner 4940 fastem 31. Date filed (Month, Day, Year) State 32. Restrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland /			Health a	ind M		jiene	0	16249
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Hester I. Laupe	ert					2. Date of Dea Month May 2	o , Day 20	10 ^{Year}	3. Time of Death 5 : 15 P M
į	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Towr	n, or Location o	f Death		<u> </u>	nty of Death	3.13 1
			Hillhaven Healt			Adel	•	A Ura				George's
	Funeral Director		5. Social Security Number 6. Sex 1571-16-1713	7. Age (In yrs. last bi		Months Day		Min.	8. Date of Birth (Month, Pay 8/3/1	⁷ , _{Year)} 913	9. Birth	place (State or Foreign ntry) .orado
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Loca	ation						0d. Inside City Limits
	Maryli I-f sho	tor	MD Baltim									1 ☐ Yes 2 💆 No
	or 28s	Direc	10e. Street and Number			10f. Zip Cod				10g. Citizen o		ntry?
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250	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "naturel", or Items 23e or 28a-f show there is no that treumatic event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:	ł	Yes, specify C	of Hispanic Orig cuban, Mexican No <i>Specify:</i>	, Puerto F	Rican, etc.)	Spe	lack, White,	
5	72 hou nature	eted	15. Decedent's Edu (Specify only highest grade	cation 16a	a. Deceder	nt's Usuai Oc	cupation ne during most tired)	of working	ng .	16b. Kind of	Business/In	dustry
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yla	ould be Menta arked arlc ev	ToE	William Earl Th	-					Tedro			
Mal	d 2 sho		19a. Informant's Name/Relationship (Ty.) Elizabeth Morrsior				eet and Numbe La Way,					Code)
Ď,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree	-	20a. Method of Disposition	20b. Place		tion (Name of atory or other)			ate		n - City or To	own, State
	Pages nent of P ent: If ite ury or of		1 ☐ Burial 2 ☒ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	ew Cr	remator	:y :					Maryland
	permit. Departr Import any inj		21. Signature of Funeral Service License	96			Idress of Facility					17. AND SAND SAND
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	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	00		nho					Interval Between Onset and Death
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NII A		BeC	25. Was case referred to dical examiner?					of Death	Check only o			
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DIVIS	To the Hospitel or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certific completely filled in y the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, to building, etc. (Specify)	farm, stree	et, factory, offi	ice	2	28f. Location (S City or Tow		mber or Run	al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (sician: To the best of my knowledg ner: On the basis of examination a and manner stated.								
	To the within To the comp	Σ	29b. Signature and title of certifier	00	2	29c. Lic	ense number	00	77	29d, Date sig	ned (Month,	Day, Year)
•			30. Name and address if a rson who co	mpleted cays death (Item 23a) (Type, Pi	10	1000	186	71	CI	-1011	71. 14.
			Madel	Co Claece	16	1055	coe	Mele	MAN	este	1006	Menter
	Sta Registr		31. Date filed (Month, Oky, Year) MAY 25 2	32. Registrar's Signature	A	have	,				a	040

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7, 2010 а М LEROY F. MORABITO 0822 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE HEALTH AND REHABILITATION CENTER GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Ye DEC. 23, 9. Birthplace (State or Foreign Country) TALY If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Min. 1 XXM 2 □ F 174.28.7199 96 Director <u>1</u>913 Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo GLEN BURNIE MD ANNE ARUNDEL 10e. Street and Number 10g, Citizen of What Country? Funeral 7355 FURNACE BRANCH RD. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify Specify: 3 XXWidowed 4 □ Divorced Completed WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ PIETRO MORABITO MARIE ANTONIA TALOTTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON JOSEPH MORABITO GLEN BURNIE 7886-T1 AMERICANA CR. MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot XX Burial 2 ☐ Cremation 3XX Be oval from State 4 Dopation 5 Other (Special MICHAELS CEM. MAY 11, 2010 BUTLER, PA 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. **GKEGORY** INK 426 CRAIN HWY. CLEN BURNLE er the tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. E isease shock, or art fai ore. Lis Immediate Cause Final disease or condition Physician, resulting in death) Medical Due Examiner Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Grekway &w Olm Basin who completed cause of death (Item 23a) (Type, Print) 08

State Registrar 32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ 0750A M Mary Elizabeth Morris 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 40 County of Death **Examiner** Batt. more Franklin Square Hospital dale Cente Year If Under 24 Hrs. 5. Social Security Number If Unde 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth Funeral Maryland 1 🗆 M 2 🔀 F Months Days Hours Min. 219 40 2115 Director 1942 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Tyes 2 K No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21220 USA 11 Chattuck Ct. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 ģ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 Tavern Barmaid other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jorris, Mary William Amos Agnes Gertrude Hasel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele D. Zambelli (Daughter) 2411 Beach Avenue Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gardens 5/25/2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ mcarcinoma, disease or condition resulting in death) Medical Due to (or as - consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed Yes 2 death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) MD E700000 5/24/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Josetha MD "ware 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 22 45 pm Lee Mizell William 20 2010 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale FRANKLIN Square Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 214-50-8667 Funeral 1 **□X**M 2 □ F Davs Aug. 12 Country Year 947 62 MD Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore Baltimore 1 🗆 Yes 2 🔀 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 5423 Hamilton Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Assembly Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie A. Underwood ဂ္ William W. Mizell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5423 Hamilton Avenue Baltimore MD 21206 Phyllis L. Mizell /wife Baltimore, 20c. Location - City or Town, State
Owings Mills MD 20a. Method of Disposition 20b. Place of Disposition (Name of Gatte somer forest 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death Arrhythmia Immediate Cause (Final Fatal Physician/ disease or condition resulting in death) <u>.</u> Medical Due to (or as a consequence of): Examiner Atheroscleratic Coronary Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? ģ Year Month Day cate has been signed by the a page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 \square No မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After of completed filled in by the funeral 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md 21237 FRANKLIN SQUARE DR 13 alto Pipkin 3 9000 DR Michael 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03859 State of Maryland / Department of Health and Mental Hygiene Jimmy McLeod, Sr. Certificate of Death 1. For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month 0912 hrs May 20, 2010 **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 447 Manse Court Nov 23 1964 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 1 M Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryiano Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, 8lack Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12 Was Decedent Ever in U.S. White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Vas 1 Yes 2 No specify: Divorced If Yes, Give Year ð 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) , MD 21215-0036 and 2 should be filed within 72 rallth and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Be Number or Rural Route Numb , City or Town, State, Zip Code) nt's Name/Relationship (Type, Print) ပ္ 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 21. Signature of Funeral Service Lic 120 Approximate Interval nter the disease, or complications that caused the death. Do not ente such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death Seizure Disorder Immedi te Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of Remote Head Injury Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit X AMENDED 8, per FH G904 6/7/10 TT 23a,b,pt.II,27,28a-f per me g906 8-10-10 vt sician/Medical W UNPENDED attending physician or use as the burial Box 68760 23d Date of delivery 23c If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Month 2 Fetal death Day 3 Ectopic pregnancy signed by the attending be detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ۵. Narcotic Use Completed 24b. Were autopsy findings available 24a Was an has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be of Vital examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death 1 Natural 1 Yes 2 X No Division Pending unknown Probable fall unknown death. filled in by the 2 X Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after d Could not be Suicide determined (Specify) unknown 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number May 21, 2010 O.C.M.E. Vac 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

ack

32. Redistrar's Signature

OCME

DHMH 17 Rev 7/2009

10-03793 Elizabeth Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 16255

		1- For State Certificate of Death			eg. No.						
Physiciar Medical Examin		1. Decedent's Name (First, Middle,Last) Elizabeth Martin		2. Date of Deat Month May 17, 20	Day Year	3. Time of Death 1853 hrs					
1		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital 4b. City, Town, or Local Rosedale	ation of Death		4c. County of Baltimore						
Funeral Director		063-56-4958 1 48 Yrs. Months Days F	f Under 24Hrs. Hours Min.	8. Date of Bird May 3,		Birthplace (State or Foreign Country) New York					
daryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State	- 10, 11 11			10d. Inside City Limits 1 Yes 2 No					
h the Mary 3a or 28a-	2	10e. Street and Number 11205 Beach Road 1162			og. Citizen of Wha Inited St						
Rer death with th "", or items 23a er must be noti	I Lune	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Widowed 4 Novered If Yes, Give Year 12. Was Decedent Ever in U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania If Yes, specify Cuban, Median Novered If Yes, Sive Year 1 No. 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispania If Yes, specify Cuban, Median Novered If Yes, Sive Year 1 No.	exican, Puerto F	Rican, etc.)	White,	American Indian, Black, etc. Hispanic					
2 hour	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Allison Transmit	NOT use retire	ed)	16b. Kind of Bus General	iness/Industry					
MD 21215-0036 and 2 should be filed within T lith and Mental Hygiens m 27 is marked other than anmatic event, the Medical	å	17. Father's Name (First, Middle, Last) 18.M		(First, Middle, M Gonzale	laiden Surname) S						
MD 2121 (d 2 should be fill lith and Mental H n 27 is marked namitic event, y	2	Natalie Ruiz (Daughter) 1324 Acorn Ridg	Natalie Ruiz (Daughter) 1324 Acorn Ridge Court,								
Baltimore, ME permit. Pages 1 and 2 st Department of Health at Important: If item 27 injury or other tranms		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory or other place) Evans Funeral Chape	Forest	City or Town, State Hill, MD							
Physician		7 917 / R Newport Dri	ervices-BelAir land 21050 t Approximate Interval								
Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Heart and lung disease complementation condition resulting in death) a. n.orphine intoxication Due to (or as a consequence of):	Between Onset and Death								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cinceres in in the light light leader).									
ecuted and transit		events resulting in death) Last Due to (or as a consequence of): d.									
760, icate be executed physician and the burial - trans		IF FEMALE: 23c. If yes, outcome of pregnancy	6/18/10	TT	23d. Date of d	elivery					
eath certification is attending for use as t		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Eccepts 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ctopic pregnan	су	Month	Day Year					
P.O. B s that the d gned by the e detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Seizure disorder	in Part I.	_		ute to the cause of death?					
of Vital Records, P.O. ng Physician: The law requires that the Note this certificate has been signed by neral director, page 2 should be detactor.	heren	Jeizure disorder		24a. Was a autops	y pri	ere autopsy findings available or to completion of cause of					
tal Reco		25. Was case referred to medical 26. Place of De	eath (Check or	perform 1 Yes 2 nly one)		ath? ✓ Yes 2 No					
f Vital Physician: er this certificatal director,	2	examiner? 1 Yes 2 No 1 No 1 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at V	Nursing		Residence 6						
Division of 'pital or Attending Phours after death. Meral Director. After tilled in by the funeral Contification: T		Natural 5 Pending (Month, Day, Yeár) 2 Accident Prending Investigation Fd 5/17/10 Fd 5:54 pm 1 Yes 2	2X No U	ınk	ow injury occurred						
Divis		3 Suicide 6 X Could not be determined Specify residence				or Rural Route Number, City Beach Rd					
Divis To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Sedical	one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an property of the death occurred at the time, date and the time, date and the death occurred at the time, date and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	th occurred at t		nd place, and due	to the cause(s)					
	-	29b. Signature and title of certifier Caral Hallan O.C.M.E.			29d. Date signed May 18, 201	(Month, Day, Year)					
Ø	3	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201								
Stat Registra	e ³	31. Date filed (North, Day Year) Anne 32. Registrates Signature 32. Registrates Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Amend Item 21 per fh,g904,06/03/2010dhb

Certificate of Death

Reg. No. 2010 16256 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2}\underline{010}$ Physician/ Ange1 **Mallory** Month May 11:23a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2801 Carver Road **Baltimore** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min. 1 M 2 X F Months Hours 49 217-86-8552 Yrs 11/05/1960 Director MD Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 2801 Carver Road 21225 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\)
Department of Health and Mental Hygiene |
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Madical Experiments 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ģ Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lorien Frankford College (1-4 or 5+) **3 vrs** Elementary/Seconday (0-12) Nursing Home yrs Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joe Brown Mildred Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel Batey - daughter 5512 Force Road, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery May 11,2010 Baltimore, MD Signature of Funeral Service Licensee per DVR 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Bernadine V. Scruggs 1412 E. Preston Street, Baltimore, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cor Pulmonale disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Right Heart Failure To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hypertensive Cardiovascular Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal Gentle Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Day Year 5 Other (specify) 9 Unknown 9 Unknown n signed by t Ild be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sleep Apnea 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed page 2 should peen Morbid Obesity 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has performed? Yes 2 No death? eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a

To the Funeral C Medical 20a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c, License number 29d. Date signed (Month, Day, Year) D28079 2010

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

egistrar's Signatu

631 Cherry Hill Road, Baltimore, MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Francine A. Higgs-Shipman, M.D., FHCB,

31. Date filed (Month UN 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. (2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 7:15 PM Thelma M. Martin Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick MultiCare Center Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 📆 🛣 96 Yrs. 212-30-5760 MD June 10,1913 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 2XXNo MD Baltimore Parkton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 Quailwood Court 21120 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XXX Specify: Baltimore, Maryland 21215-0036 Specify: White 3∰Widowed 4 ☐ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) United Lady Garment Elementary/Secondary (0-12) Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Willey Rose Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Mary Baggett (Daughter) 9 Quailwood Court Parkton, MD 21120 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/22/2010 Parkville, MD Parkwood Cemetery 22. Name and Address of Facility 3631 Falls Road Burgee-Henss-Seitz Funeral Home, 21. Signature of Funeral Service License Balto, MD 21211 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknewn Hugneed Clementia Physician /Medical Due to (or as a consequence of): un knowh Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Tes 28b. Time of 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosi within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier gregor MB May 21, 2010 D Habelle 013657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NBNBELLE THERE BOR, 700 W. 40 HL STREET, BALTIOTORE, OD 21211 Moerk BoR, PAMELIE 32. Registrar Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Patrick Vernon Murphy 2010 16258 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 21, 2010 Medical Examiner PATRICK 2315 hrs VERNON MURPHY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 353 Homeland Southway, Apt. 3B None 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Foreign Director 185-50-6878 1X M 2 F 37 01-13-1973 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Y Yes 2 No Maryland None Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 382 Homeland Southway #1B 21212 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XX Never Married 2 Married 1 Yes White 1 Yes 2 No specify: If Yes, Give Year Specify: 3 Widowed 4 Divorced ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. Titem 27 is marked other than " or traumatic event, the Medical Lawyer Tax 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Vernon Murphy Paula Gabig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAula Gabig Murphy Mother 353 Homeland Southway Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place Burial 2 X Cremation 3 Removal from State GreenMount Crematory Baltimore, Maryland 5/24/10 22. Name and Address of FacMittchell-Wiedefeld Funeral Home Signature of Funeral 6500 York Road Baltimore, Maryland 21212 Approximate Interval ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on e Retween Onset and Medical Death Hanging Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician for use as the burial The law requires that the death certificate be Box 68760 23d, Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed by a director, page 2 should be detached 2 1 Yes 2 No 3 Probably 4 Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? page Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: æ examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. injury at Work? Subject hung self t Hosping.

0.24 hours after death.

ne Funeral Director: A 1 Natural FOUND: 1 Yes 2 ✔ No Pending May 21, 2010 2305 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 382 Homeland Southway, Apt. 3B, Baltimore, Md determined (Specify) Multi-Family Apt. Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cort (A) May 22, 2010 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Unit State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Timothy 2010 Brian Murphy 2:41PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6420 Oak Park Court Linthicum Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours July 5, 1952 57 215-64-2838 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6420 Oak Park Court 21090 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene. If Yes, Give Specify: White 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Assistant Inspector General N.S.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carroll Murphy Selma Critzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health a portant: If item 27 is / injury or other trai Mrs. Emily Murphy/ Wife 6420 Oak Park Ct. Linthicum, MD 21090 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 5/26/2010 Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. P. 1. Enter the disease, or completions that caused shock, or heart failure. List only one cause on each line. or complifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ Concer cre an disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner quentially flat conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician ad be detached for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? 2 🗆 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗆 Yes 2 ပ္ 1 Inpatient 2 ER/Outpatient 3 I ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) thours after death.

uneral Director: After the filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in 24 hour.

o the Funeral Dr

completed fille Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date file (Month, Day, Year)

169

Box 68760

P.0.

Records,

Division of Vital

of death (Item 23a) (Type, P

Registrar's Signature

5017

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1/4/

OrNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g903 5-25-10 vt.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	rtificate of			Reg. No.	10	16260
5	Physicia	an	Decedent's Name (First, Middle,					2. Date of De Month	Day	Year	3. Time of Death
4	/Medic		Robert Carson Mi 4a. Facility Name (If not institution,			4b. City. Town, o	Location of Death	May 14	4c. County	of Death	8:15 FM
	Examin	er	28 Elinor Avenue			Fullert			Balti		
	Funeral			. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Bir	th		lace (State or Foreign
100	Director		233-40-6354	1 X M 2□ F	81 Yrs.	Wolfuls Days	Hours Will.	Feb. 8,	1929	West	Virginia
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
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	r 28a-	Director	10e. Street and Number		Dartimore	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	th with	al D	2261 Syndey Aver	ue		21230			U.S.A.		
	ems :	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S an. Mexican, Puert	pecify Yes or No	- 14. Rac	e - Americ k, White,	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X Divorced		o	1 □ Yes 2 🛛 No	Specify:			Whi	
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7	Physician		Immediate Cause (Final disease or condition resulting in death)	_aĊ	OPD						IYEAR
V	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
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€8760,⊕	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
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Вох	that the death certified by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	PEtal death 3□	Ectopic pregnancy	/			te of delive nth	ery Day Year
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or	Physi this c	To.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injury	t 2 ER/Outpatier		er: 4 🗆 Nursing F	lome 5 Res	idence 6 XOth	er (Specil	daughter's residence—
Ou	ding h. After funer	tjou	1 Natural 5 ☐ Pending	(Month, Day		Wor	k? Yes 2∐No	Zod. Describe	now injury occur	eu	
Division or Vital Records,	or Atten after deat Director; in by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	be 280 Place of injur	l y - At home, farm, sti <i>(Specify)</i>				Street and Numb wn, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical Ce		Physician: To the best o	examination and/or in						
	o the	Mec	29b. Signature and title of certifier	and manner stat		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
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	Sta Registr		or. Date filed (World, Day, 1881)	52. Tagletta	5 Signature	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2010 Month Physician/ 9:40a May Merrick McCraw Ralph Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner **Baltimore** Dundalk 6736 Danville Avenue 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 **Funeral** (Month, Day, Days Min. Months 1 XM 2 F Maryland Director 212-36-2475 Isual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director 1 Yes 2X No Dunda1k **Maryland** Baltimore 10g. Citizen of What Country? ō Examiner must be Funeral 23a United States 6736 Danville Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No 1957—
If Yes, Give death v 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married "natural", or ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Oil Company Burner Service Mechanic GED Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fileo. Department of Health and Mental Health properties. If item 27 is monary injury or other. 17. Father's Name (First, Middle, Last) ည Lelia B. Beckett Luther E. McCraw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6736 Danville Avenue, Dundalk, Maryland 21222 Patricia A. McCraw/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/24/2010 Baltimore, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury r a consequence of): burial-transit that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 9 Unknown a Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 1. brillat Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2X No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 1 Yes 2 No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending X Natural М Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29d. Date signed (Month, Day, Year) nd title of certifie 29b. Signature 0 0055171 M.D

Registrar

State

Prenu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO HOW

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10

SEBASTIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per fh 9903 5-25-10 vt State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** MILLS 20 530P™ 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL SYKESVILLE OPPER **DGE** 6. Sex 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 □ F Yrs WEST VIRGINIA 88 SEPT. 201-07-0716 29,1921 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □No r 28a-f sh notified Directo MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r 4010 BIXLER CHURCH RD 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE ρ Specify: 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAY ROBERT ESKEY, SR. LORENA AGNES HUSHION P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 BIXLER CHURCH RD WESTMINSTER, MD 21158 JODY BEALL-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State ATLANTIC CREMATORY 5/22/10 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jessica Hogg

Per dvr (M01333)

22. Name and Address of Facility 6415 BELAIR

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 6415 BELAIR RD BALTIMORE, MD 21206 کے BELAIN Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** 1)ementic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed certificate 1□ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1. Natural 1 □ Yes 2 □ No 2 Accident Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 710 Obrecht Rd, Sykosville, Maryland DANK RONNIE

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene										
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death						
	Physicia Medio		Roy Suttle		May 21	Day Year	5:50 aм				
	Examin	ier	4a. Facility Name (if not institution, give street and number) Casey House Montgomery Hospic	e Ab. City, Town, or Location of Death Rockville	1	4c. County of Death Montgomery					
П	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last be 1 1 □ M 2 □ F 59	oirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.							
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			0d. Inside City Limits				
:	Maryla 28a-f s otified	irect		Washington			1 🏿 Yes 2 □ No				
:	with the s 23a or ust be r	Funeral Director	10e. Street and Number 1884 Columbia Road, #906	10f. Zip Code 20009	10	g. Citizen of What Cour USA	ntry?				
36	mer death ", or item: aminer m	ڇا	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ⚠No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e					
00	nours a natural ical Ex	leted	3 Widowed 44 Divorced Year or Dates. 15. Decedent's Education 1	6a. Decedent's Usual Occupation	10	Specify: WI1.					
21215	vithin /2 jene. sr than "r the Med	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4	(Give kind of work done during most of work life. DO NOT use retired) Journalist	king	Media					
/land	and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. Em 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Roy D. Mark	18. Mother's Nam Joan	ne (First, Middle, Ma. Suttle	iden Surname)					
, Mary	ed 2 should ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Susan Delbert / Executrix of the Will	9b. Mailing Address (Street and Number or Run 6035 B. Broad Street,			Code)				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportant if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Rurial 2 Ocremation 3 Removal from State ceme	etery, crematory or other place)	Date 20 1/2010	Oc. Location - City or To Woodbine,	· .				
Balt	permit. Departi Import any inj		21. Signature of Euneral Service Licenser Dorrota Marshal	1 22. Name and Address of Facility Cre Mary Land Cre PO Box 1413,	emation Se Baltimor	ervices ce, MD 2120	3				
•	hysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adeno carcinoma Due to (or as a consequence spleen and bone	a of rectum with metas			Approximate Interval Between Onset and Death				
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	10/201							
000	ohysician and the bunal-transit	al Exan	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of t	e of):							
3760	g physic as the b	l edical	d								
Division of Vital Records, P.O. Box 687	Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	ery Day Year				
s, P.O.	signed by	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		cco use contribute to th	37				
Record	certificate has beer lirector, page 2 shou	Completed			24a. Was an autopsy performe 1 Yes 21	prior to cor	osy findings available mpletion of cause of				
/ital	certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Xivo	26. Place of Death (Chec.	k only one)		Hospice				
	After this	ate: To	I □ inpatient 2 □ EN	Time of 28c. Injury at work?	ome 5 ☐ Residence 28d. Describe how	e 6 🔼 Other (Specify) injury occurred	поэртее				
Vision	ifter death	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,				
O Pictoria	Funeral L	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check 2 Medical Examiner: On the basis of examination and	a, death occured at the time, date and place, ar d/or investigation, in my opinion, death occurred a	nd due to the cause(s) and manner as stated	d. use(s) and manner stated.				
7 6 6	within 2 To the comple	Me	only one) 3 Certifying Nurse Practioner: To the best of my knot 29b. Signature and title of certifier	owledge, death occurred at the time, date and place 29c. License number	ce, and due to the ca	use(s) and manner as sta I. Date signed (Month, Day 22	ited.				
			30. Name and address of person who completed cause of death (Item 23a	MD D 0060634	1	ray 22	, 2010				
			Bindu Joseph, M.D. 6001 Munca	aster Mill Rd., Derwoo	od, MD 208	355					
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registar's Signature	A. parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4c. County of Death Examiner ti Mo 8. Date of Birth **Funeral** holace (State or Foreign 1 M 2 F Months Hours Director iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ant's Na Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 4 mo. Medical Due to (or as a consequence of): **Examiner** mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Theuasma After this certificate has autopsy performed i zure de Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 No 2 Accident
3 Suicide Investigation Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner-To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRSN. EUTAW ST. Balo 21201 31. Date filed (Month, Day, Year) State MAY 2 Registrar

DHMH 17 Rev 7/2009

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private.	Examir		4a. Facility Name (if n	KINS P	AYVIEW M	EDILAL			BALT	Location	LE		4	c. County	of Death		
	Funeral Director		5. Social Security Nur 218-20-64 Usual Residence of E	¥66	6. Sex 1 🙀 M 2 🗆 F		. last birthday) 33 Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Date C	rth ay, Yeard	26	9. Birthp Mary	lace (State or Fore	əign
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Maryland 2	ntal Hygi ed other	To Be	17. Father's Name (Fi	rst, Middle, L	ast)		ını.	LIWII	giic			ne (First, Middle,				teeı	
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ž	id 2 st salth a n 27 is er tra				ola/daugh	ter						Abingdo				ode)	
Baltimore,	. Page 1 ar ment of He tant: If iten jury or oth		20a. Method of Dispo 1 ☐ Burial 2 ☐ 4 🛣 Denation	Cremation	Removal from	State 20b.	Place of Dispo cemetery, cren	sition (Na.	me of			Date			City or Tov	vn, State	
Ball	permit Depart Impor any in		21. Signature of Fund	na Id	Censee	recto	22							Bal	timor	e Street	
7	Physician/ Medical Examiner		23a. Par 1. Enter the shock, or heart Immediate Gause (Fi disease or condition resulting in death)	failure. List o inal	nly one cause on ea	ch line.	ath. Do not ente	r the mod	de of dying	g, such as	cardiac	and 212(or respiratory ar	rest,		- 1	Approximate Interval Between Onset and Death DAYS.	
Q	be executed rsician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):															
. Box 68760	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9	onths?	23c. If yes, out	Birth 2 🗌 Fe nant at time of	tal death 3	Ectopic Other (s)		у				23d. Dat Mor	e of deliver	y Day Year	
ls, P.O.	w requires that the sbeen signed by should be detact	ρ	Part II. Other signific	ant conditio	ns contributing to d	eath but not re	esulting in the u	nderlying	cause give	en in Part I	l.					cause of death?	own
Division of Vital Records,	The law requate has been page 2 shou	Completed										24a. Was autop perfo 1 Yes	osv	D	rior to com leath?	sy findings availab pletion of cause o	ele of
al F	ysician: The is certificate director, pag	Be C	25. Was case referred examiner?	to medical					26. Pla	ce of Deat	th (Chec	l L Yes k only one)	2 LY N	0 1	☐ Yes 2	2 □ No	
Ξ	S S	2	1 🗆 Yes 2 😿	No			☐ ER/Outpatien	3 🗆 D	OA Othe	r: 4 🗆 Nu	ırsing Ho	ome 5 Resid	dence 6	6 🗌 Othe	r (Specify)		
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Divis	e Hospital or Attend 124 hours after death e Funeral Director: A		4 Homicide	determi	ned 28e. Place buildir	ng, etc. (Speci						28f. Location (S City or Tow	ın, State)			
	the Hosp thin 24 ho the Fune mpleted f	Medical	(Check 2 L		Physician: To the beaminer: On the bas Nurse Practioner:	is of examination	on and/or investi	gation, in	my opinior	n, death oc	curred a	t the time, date a	nd place	and due	to the caus	e(s) and manner st	ated.
	To the Comple		29b. Signature and titl		morgan	200	-	290	License RES	number)			-	(Month, Da		
			30. Name and address	s of person v	ho completed caus	e of death (Ite			JUE	201	T18A	OPE M) 1.	17.7.A			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 William Jesse Nine 7:12 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> 13 Harrison Avenue Middle River Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🕅 M 2 🗆 F Davs Hours May 19, 1940 70 **Director** Maryland <u> 218–36–6861</u> Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Harrison Avenue 21220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) Foam Manufacturing Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Long Arley Nine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Patricia Susan Nine (Wife)</u> 13 Harrison Avenue Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 25, 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Sign ure of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a (Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse pence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav by the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending in 24 hours after usur...the Funeral Director: Aft Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 3 Spectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 404

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NETLA E. Sanchez

31. Date filed (Month, Day, Year)

- Cre

8120

strar's Signature

00067697

Eastern Bluel,

Essex

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ MARLEY EDWARD NULL MAY 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD COUNTY If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Hours Feb. 19, 1933 West Virginia Director 218-28-8073 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 8720 Ridge Road Apt.202 21043 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 0 5 1 14. Race - American Indian. rces? 2 N1951-e. 1955 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify.White "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Truck Driver Delivery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I 2 Marion Francis Mary Agnes Cox . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8720 Ridge Road Apt. 202, Ellicott City, Maryland 21043 <u>Louise A. Null, wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 5/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. |Baltimore, Maryland 21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facilit MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, ACUTE COPD EXACERBATION WITH RESPIRATORY disease or condition resulting in death) Medical FAILURE Due to (or as a consequence of) Examiner RENAL FAILURE Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant g ☐ Unknown Yes 2 ☐ No 1 ☐ Yes 2 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORDER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed Yes 2 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mywey MD D0064760 MAY 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYTHILY VANCHA 10710 CHARTER DRIVE, COLUMBIA MD 31. Date filed (Month, Day, Year) 32. Registra State Registrar

DHMH 17 Rev 7/2009

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AMEND TEM# 20b, perFH, G903, 5/25/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year RTRUS 530 MM 2010 /Medical (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show er than "natural", or items 23a or 28a-f show KaHimore Completed by Funeral Director 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 items 23a USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) 10th Is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edmond ဥ permit. Pages 1 and 2:
Department of Health a
Important; If item 27 Is
any injury or other trau Kewin Avenue Kaltimore Maryland Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tra P.O. Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery for Live birth 2 🗌 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 A 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \(\sum \) Nursing Home Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Isedo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGITAL M DY 31. Date filed (Month, Day, Year) MAY 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Ann Phyllis Owensby 22 129 A M 5 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Rosedale Hospital FRANKLIN Square If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Vear 1 □ M 2 🔀 F 217 38 4446 **Director** 69 March 1, 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location D. partment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner mass be notified at one. 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore **Essex** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1314 Cherry Garden Rd. 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Financial Officer Furniture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Stanley Malon Sophia Irene Kehne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Owensby Jr. (Husband) 1314 Cherry Garden Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1☑ Burial 2☐ Cremation 3☐ Removal from State Holy Rosary Cemetery 15/27/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Pa/11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arrest Cardiac disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner and retroperitoreal bleeding Intra-abdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or es a consequence of): The law requires that the death certificate be executed intravascular coaquiation Disseminated attending physician and for use as the burial-tran Due to (or es a consequence of): Box 68760, Physician/Medical Lung metastatic Cancer 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Onknown this certificate has been siral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) الادرز RESODOO

State Registrar

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Square

9000 FRANKLIN

32. Registar's Signature

DR Balti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taria

DR Fawa D Ta 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MICHAEL D. ODOMS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A 5. Social Security Number ge (In yrs. last birthday) A. Date of Birth MAY 1, 1955 Funeral Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ F 55 Yrs. MD Director 146-50-6176 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director 1 Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or 21201 USA 501 WEST FRANKLIN ST Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1.X Never Married 2 ☐ Married ò 1 ☐ Yes 2 📉 No þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) L Unemploy never is marked other 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Menial 19a. Informants Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Danne Important: if item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Sign were of Funeral Service Lice 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Iteratorenel
Due to (or as a consequence of): Eyndrom /Medical Examiner Circhosis Sequentially list conditions, if any, leading to immediate cause. Linter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O, Box 68760, Physician/Medical use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Lo 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Magner of Death 28a. Date of Injury 28h Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) KYLE MARSHALL, MO State Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Mary Jane Padgett 2010 P M May 14, 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens of Tuckerman Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 294-40-8252 Director April 4, 1916 Ohio Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Maryland | Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 9910 Old Spring Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If ifem 27 Is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must. 20895 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No. Completed by Specify. Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Arthur Coe ၉ Julia Mae Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9910 Old Spring Rd., Kensington, MD 20895 <u>Philip Padgett</u> (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Metropolitan Crematory 5/17/10 4 ☐ Denation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Lice, see 22. Name and Address of Facility Funeral Home-Afton Chapel Gravois Rd., St. Louis, MO ellun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Atherosclerotic Heart Disease nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be Dementia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4⊡Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∏ Yes 2X No certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death I Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exa r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53691 May 17, 2010 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) Ajay Reddy, MD3200 Tower Oaks Blvd #110 Rockville, MD 20852 barker 31. Date filed (Month, Day, Year) Registra State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RUSSE DORRIS 20 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8814 E MD -11 mores Social Security Number . last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min. (Month Day, Year) Cority inois 347-12-4442 Director 1920 Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2-No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 8814 Baker Avenue 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural" White 3 Widowed 4 Divorced Year or Dates. \ permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Pirtle Clora Ethel Bridgeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia West /Daughter 9506 Dawnvale Road Nottingham, MD 21236 Baltimore, Date May 26 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Parkville, Maryland Parkwood Cemetery 2010 4 Donation 5 Other (Specify) 22. Nam Cremation Fand Funeral Alternatives Signature of Funeral Service Licensee M0144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ OB disease or condition Medical resulting in death) **Examiner** equantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be the 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2

State Registrar

7 31. Date filed (Month, Day, Year,

only one)

30. Name and

29b. Signature and title of cer

32. Registra 's Signatu

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Pate signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur W. Pitts 2010 Medical May 10:00a ^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stonehearth Road Severn Anne Arunde1 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 X M 2 - F 92 Days Hours (Month, Day, June 3, Director 291-01-6266 1917 Ohio Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d, Inside City Limits Maryland | Anne Arundel 1 Yes 2 No Severn 10e. Street and Number 10g, Citizen of What Country? by Funeral 7910 Stonehearth Road 21144 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Foreman United Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Willis Pitts Amanda Jane Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald A. Pitts/ Son 7910 Stonehearth Road, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/24/2010 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 🕪 Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final BRAIN Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal 555. ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ORGNARY ARTERY DISEASE Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown PULMONAGE EMBOLISM 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed certificate Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗙 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The within 24 hours after de To the Funeral Directo completed filled in by the

> State Registrar

only one 29b. Signature and title o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

450 KNOLL NORIVE, SUITE 260 COLUMBIO, MO 21045

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 0630AM Month Physician/ Mildred Veronica Pusateri MOLL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dalh now tal mire Social Security Number 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 M 2 XF Hours Min. Feburary 15, 1927 Mary Irand Director 212-26-5299 350 + BV Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Bel Air 1 🗆 Yes 2 🔁 No Harford Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 914 Leeswood Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Mr. I dsed 12. Was Decedent Ever in U.S 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3
Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "no any injury or other traumatic even." Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Hairdresser Be 18. Mother's Name (First, Middle, Maiden Surname)
Nunzia DePasquale 17. Father's Name (First, Middle, Last) Calergo Assero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Leeswood Road Bel Air Maryland 21014 Jo Ellen Slechter / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Most Holy Redeemer Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/28/10 Baltimore Maryland 12 Name and Address of Faciliting 5305 Harrford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ari hour. disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Day Pregnant at time of death 9 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Correnana toss 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 1 🗆 Yes 2 🗡 👊 Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ppatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Dath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatur D001199 du who completed cause of death (Item 23a) (Type, Print) SINM HOSPITM OF BRITMONE 31. Date filed (Month, Day, 32. Registr 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

10-03810
Wendell Porter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifica Registrar	ate of Death	Reg. No.	
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Wendell T. Porter		2. Date of Death Month Day Ye May 18, 2010	1308 nrs
		 Facility Name (if not institution, give street and number) 825 Whitelock Street 	4b. City, Town, or Location of Deat Baltimore	th 4c. County	of Death
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birth \$\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	nday) If Under 1 Year If Under 24Hr Months Days Hours Mii Yrs.	-	9. Birthplace (State or Foreign Country)
nd show any ace.	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town NA Part	or Location Himore		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show uotified at once,	Director	10e. Street and Number 825 Whitelock St.	10f. Zip Code 2/2/7	10g. Citizen of W	/hat Country?
fiter death with the Maryland I", or items 23a or 28a-f sho ter must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes No specify:		e - American Indian, Black, te, etc.
2 hours al "natural Examin	ompleted by	15 Decedent's Education (Specify only highest grade completed) 16a [Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	f work done atired)	usiness/Industry wront
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Examin	Be Comp	17. Father's Name (First, Middle, Last) (NMS DAVIS	0K 18 Mother's Nam Mario	ne (First, Middle, Maiden Surname	
MD 212 d 2 should b lth and Men n 27 is marl	ToE	19a. Informant's Name/Relationship (Tipe, Print) 19b. 19c. Informant's Name/Relationship (Tipe, Print) 19b. 19c. Informant's Name/Relationship (Tipe, Print)	Mailing Address Street and Number or RS Whitelock St.	Rural Route Number, City or Tov	wn, State, Zip Code)
Baltimore, Nemir. Pages I and Department of Healt Important: If item injury or other trau			f Disposition (Name of cemetery, pry or other place) On Cemetery 5-2		- City or Town, State OWNE, MD
	l l	21. Signature of Funeral Service Licensee 23a Part / Enforthe disease, or complications that caused the death. Do no	22/Marge and Address of acility And FRedhill 1900	Tuperal Hom Tass Batto.	ent Approximate Interval
Physician /Medical xaminer	(C. 3)	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		or respiratory arrest, shock, or rie	Between Onset and Death
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			_
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760, cate be executed physician and he burial - transit	Medical E	d. UNPENDED AMENDED			
OX 687 ath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	23d. Date of Month	f delivery Day Year
i, P.O. Be ires that the de signed by the I be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		ribute to the cause of death?
of Vital Records, ag Physician: The law require. After this certificate has been signeral director, page 2 should be	Completed			autopsy	Were autopsy findings available prior to completion of cause of death? Yes 2 No
ital Recision: The scernificate rector, page	Be	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check tpatient 3 DOA Other Nursing		
on of V anding Phys ath. r: After thi	tion: To	1 Ves 2 No Impation 2 21668 27. Manner of Death 1 Natural 5 Pending 28a Date of Injury (Month, Day, Year) 28b. T	tpatient 3 DOA Ourer4 Nursii ime of Injury 28c. Injury at Work? 1 Yes 2 No	ng Home 5 Residence 6 28d. Describe how injury occur	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, fair determined (Specify)	rm, street, factory, office building, etc.	28f. Location (Street and Numb or Town, State)	per or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check orly 1 Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date sign May 18, 20	ned (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	1D 21201	
St Pegist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A back DOME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2142 ames 2011 Herman MCI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 1emoria Himore 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours **Director** 28a-f show 10a. State 0b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral Ceci items 23a 4 venue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ö þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, ပ Baltimore, Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) larulano 21. Signature of Funeral Service/Lice any in Our 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Jes disease or condition hear Medical resulting in death) Due to (or as a consequence of) Examiner VICES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant a Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has autopsy perform 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ၉ 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d, Describe how injury occurred After injury Natural 5 Pending Accident 2 🗌 No 124 hours after death e Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) T2438946-B2 30. Name and address of person/who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31, Date filed (Month, Da), Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) WALTER 2. Date of Death 3. Time of Death V. PANOWICZ Month Year 05 pM 5 13 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 86 Yrs. Months Days Hours M 2□ F 5-26-1923 216-12-9669 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits BALTIMORE MD ROSEDALE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8504 DAYTONA ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) POLICE SERGEANT POLICE DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY (ROSZYK) JOHN STANLEY PANOWICZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8504 DAYTONA ROAD ROSEDALE, MD AGNES D. PANOWICZ/WIFE 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS CEM 5-22-10 DUNDALK, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational be retified at any Injury or other traumatic event, the Medical Examination and Department.

Maryland 21215-0036

Baltimore, 2

/Medical

Funeral Director

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Completed

Be (

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To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar 30. Name and address of person who complete

ngyyen

DR Binh

31. Date filed (Month, Day, Year)

ı	Immediate Cause (Final disease or condition resulting in death)	a. Subdurat he	matoma.	· ~ .	SAY Sealing
Completed by Physician/Medical Examiner	Sequentially list conditions, if any leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cue to (or as a consequence of): c. Due to (or as a consequence of): d.	Marcoss	Add N. Cite	roll by D.
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy ner (specify)		23d. Date of delivery Month Day Year
leted by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underl	lying cause given in Part I.		se contribute to the cause of death? TO 3 Probably 4 Unknown 24b. Were autopsy findings available
				autopsy performed? 1 □ Yes 2 □ Ho	prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
10	1 res 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 \sum Nursing He	ome 5 ☐ Residence 6	☐ Other (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at	28d. Describe how injury	To church
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At nome, farm, street, f	factory, office ments church	28f. Location (Street and City or Town, State)	Number or Rural Route Number, 205 Colal acco Ave mal 2123
edical	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exam one)	yslcian: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death occu	, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)
Ž	29b. Signature and title of certifier		29c. License number	29d. Date	e signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Franklin Square DR

NGOID

of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature

1)65094

5-19-2010

Balto md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylanc		artment of H		and M	lental Hy	giene		
			1 - State Registrar			Cer	tificate of D	eath			Reg. No.	10	16278
	Physicia	ın/	Decedent's Name (First, Middle, I	Last)						Date of Dea Month	Day	Year	3. Time of Death
	Medic	cal	GTORTA TEAN F 4a. Facility Name (if not institution, g							MAY 20	<u>, 2010</u>		8:52 P M
	Examin	ıer	8 Irish Road	iive street and number)			4b. City, Town, or Bel Air		of Death		4c. County of Death Harford		
	Funeral			. Sex 7. Ag	e (In yrs. las	t birthdav)	If Under 1 Year	If Under	24 Hrs. T	8. Date of Birt			place (State or Foreign
	Director		218-44-6342	1 □ M 2 X F	65	Yrs.	Months Days	Hours	Min.	Jan. 3	Year) 1945	Coun	yland
	, MO	١.	Usual Residence of Decedent							00011	,		
	ryland -f sh ed al	용	10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	e Ma r 28a notifi	Sir.	Maryland Harford 10e. Street and Number		Bel	Air	Trac Trac						1 💆 Yes 2-🗔 No
	/ith th	a					10f. Zip Code				10g. Citizen of	What Cour	ntry?
	ems r mu	Funeral Director	8 Irish Road 11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	21014 /as Decedent of His		ain? (Sper	rify Yes or No-	USA	ce - Americ	on Indian
ထွ	ter de or it	by F	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 🔀		If	Yes, specify Cubar	n, Mexicar	n, Puerto F	Rican, etc.)		ck, White,	
Maryland 21215-0036	urs af		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🔀 No	Specify:			Specif	v: Wh	ite
5	72 ho "na'	Completed	15. Decedent's (Specify only highest			(Give k	ent's Usual Occupa ind of work done d		t of workin	g	16b. Kind of E	Business Ind	dustry
2	ithin ene. r thar	Con	Elementary/Seconday (0-12)	College (1-4 or 5	′		NOT use retired)				•		
Ö	Hygi Hygi othe ent,	Be	17. Father's Name (First, Middle, Las	et)		Homema		18 Mothe	er's Name	(First Middle i	Own Maiden Surnam		
lan	d be fi fental rked tic ev	임	Lawrence Verno	n Minton							nerine	/	eston
a _Z	should and N is ma suma		19a. Informant's Name/Relationship	(Type, Print)	- 1	19b. Mailin	g Address (Street ar						
Σ.	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Bernard H. Palm	Jr., Husba	nd		cish Rd.,						
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from State	20b. Pla	ce of Dispos netery, crem	ition (Name of atory or other place	•)	D	ate	20c. Location	- City or To	wn, State
Baltimore,	t. Pag tmen tant: ijury		4 Donation 5 Other (Spe		Hill:		ervice Co		5-26		Towson	. Mar	yland
a R	permit. Page Department of Important: If any injury or once,		21. Signatur of Funeral Service Lio	see		Mc	Name and Address COMAS Fu	of Facilit nera.	L Hom	e, P.A.			
			23a, Fart 1. Enter the disease, or co	mulications hat caused	the death	Do not enter	317 Cokes	bury	Road	, Abino	rdon, M	aryla	
١,	The same of		23a. Fart 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one ause on each line	. Co	O ₂	the mode of dying	, such as	Cardiac or	tespiratory arre			Approximate Interval Between Onset and Death
	hysician/ Medical		disease or condition resulting in death)	a. Due to (or as a	27C		ncreation		1	1 Ce	11 Can	CEY	5 years
	Examiner			220 10 (0. 40 0	Consequen	100 01).							1
-		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Lue to (or as a	Conseque	ice ol).							
),	and trans	хап	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a									
	cate be executed physician and the burial-transit	edical E	resulting in death) cast	Due to (or as a	Consequer	ice oi).							
00/	icate j phys is the			d									
00	certif ending use a	Ž/V	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnanc						23d. Da	ate of delive	erv
POX	ding Physician: The law requires that the death certific. h. Affer this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth : 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)						Day Year
5	t the	Phġ	9 Unknown		_					_			
7 <u>.</u>	es tha igned be de	\$	Part II. Other significant conditions	contributing to death bu	it not result	ing in the un	derlying cause give	n in Part I					e cause of death?
records,	equire	eted								1 🗆 Y	es 2 No	3 ∐ Prob	ably 4 Unknown
ည သ	has b	Completed								24a. Was a autops	SV	prior to con	sy findings available npletion of cause of
ř	n: The ficate r, pag		25. Was case referred to medical							1 🗆 Yes	meg? 2 X No	death?	2 X No
	sicial certi irecto	m	examiner? 1 Yes 2 No	Hospital:			Other	ce of Deat					
5	g Phy er this eral d	은 ::	27. Manner of Death	1 Inpatie	y 28	b. Time of	28c. Injury a	_4 ∟ Nu at			ence 6 Oth		
5	andin ath. rr: Aft	icat	1 Natural 5 Pending 2 Accident Investigati		Year)	injury	M 1 🗆 Y	es 2 🗆	- 1		,,		
NSION .	or Atta	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home (Specify)	e, farm, stree	t, factory, office		2	3f. Location (St. City or Town	reet and Numb	er or Rural I	Route Number,
5	pital c								1		,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 \(\subseteq Medical Exains)	nysician: To the best of r	amination ar	nd/or investic	ation, in my opinion.	, death occ	curred at the	ne time date an	diplace and du	a to the caus	ea/e) and manner etated
1	To the within To the Comp		only one) 3 Certifying Nu 29b. Signature and title of certifier	urse Practioner: To the b	est of my kr	iowieage, ae	29c. License r		and place,		cause(s) and mage 9d. Date signer		-
			Sanot (the my	0		DUG	118	,		MAU -	21 .	2010
			30. Name and address of person who		ath (Item 23	Ba) (Type, Pri	nt)	., 0	01	, ,	1		1 2
	Ctot		31. Date filed (Month, Day, Year)	ER MD	+16	H.	>ecunit	4	RIVO	WI	ndsor	MIL	1 MD 21244
	State Registra	~	MAY 9	32. Regignar	s oignature	1. 1	barker	1					•
			17 14 1 6 4		A	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald J. Reckline 2017 2025 PM Medical 4a. Facility Name (if not institution, give street and number) Çity, Town, or Location of Death Examiner 4c. County of Death Franklin Square ROSEdale Bahimora 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8 Date of Birth 1 XM 2 □ F Months Hours (Month, Day, Year) Feb. 10, 1955 215 66 1830 Director 55 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1311 Second Rd. 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married ۾ 1 Yes : 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Chain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Reckline Margaret Kirkendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Burkhardt (Neice) 99 Coulson Dr. Colora, Maryland 21917 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 5/27/2010 Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as) IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery fort 3 Ectopic pregnancy in the past 12 months? 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month 2 🗌 No the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🕶 No Other: မှ 1 Tyes 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manher of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certif D0054428 10

State Registrar

30. Name and address of person who completed ca

SOURCE DRIVE BUILDINGE MD 21237

se of death (Item 23a) (Type, Print)

Registrar's Signature

Lower

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 010 16280 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 20, 2010 Lillian Ida Ray Medical Examiner 0725 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Foreign Baltimore, Days Months Hours Director 220-18-9038 May 18,1926 1 M 2 XF 84 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore County Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

out: If item 27 is marked other the "." iant; If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 8820 Walther Blvd. unit3204 21234 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes White 3 Widowed 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker N/A Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Brandt æ Wilhemenia Prieber ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janis A. Collins (Niece) 12433 Warner Road Maryland Keymar, 21757 Oc. Location - City or Town, State (Harford County) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place)
Evans Funeral Chancel and 1 Burial 2 XCremation 3 Removal from State May 22,2010 Department or Important; Cremation Services | Fuest next, rary
hir, Sr 22. Name and Address of Facility
Peaceful Alternatives Fueral & Cremation Center,
2325 York Road Timonium, Maryland 21093 Forest Hill, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Jeffrey L. Part I. Enter the disease, of complication failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. è 1 Yes 2 No 3 Probably 4 V Unknown Renal disease Completed page 2 should been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural 1 Yes 2 No 5 Pending filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 21, 2010 Dais 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Ye 32. Registrar's Signature State 25 Registrar

10-03802 Michael Rhodes		Please Type or Print in Black Indelible Ink. Ensure All Copie		jible.	1000
WICHAEL KHOUES		State of Maryland / Department of Health and Mental H 1- For State Certificate of Death		ZUIL	1520
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Deat Month	g No. h Day Year	3. Time of Death
Medical Exami	ner	Michael Rhodes	May 18, 20	010	0854 hrs
1 1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatt Union Memorial Hospital Baltimore	h	4c. County of Death	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Mir	_	h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		212-87-9253 1⊠ M 2□ F Yrs. 6 Wrs. 6	Nov. 2	8,2009 co	untry) Md.
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show must be notified at once.	tor	Nd. NA Baltimore			1 Yes 2 No
e Mary or 28a	Director	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Coul	ntry?
with th	ralD	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	can Indian, Black,
death v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	,
after	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	acK
2 hours afte "natural", Examiner	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College {1-4 or 5+) College {1-4 or 5+)		16b. Kind of Business/I	ndustry
36 in 7 han lical	Completed	NIA NIA Bahu		NIA	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 77 bepartment of Health and Mental Hyggene. Important: If item 27 is marked other than nijury or other traumatic event, the <u>Medical</u>		17. Father's Name (First, Middle, Last)	e (First, Middle, N	laiden Surname	
2121 Muld be fi Mental I marked	Be	19a. Informant's Name/Relationship (Type, Print O. L 19b. Mailing Address (Street and Number or	DNTA Bural Bouta Num	BOYA State	Zin Code)
MD 2 d 2 shoul lth and M n 27 is m numatic	T ₀	19a. Informant's Name/Relationship (Type, Print Porter) 19b. Mailing Address (Street and Number or 12831, Keinturk Ku	ALLA	Ra 1 to 1	11/12/21
nore, MD ages 1 and 2 sho nt of Health and 1: If item 27 is other traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
altimore, rmit. Pages I an epartment of Hea portant: If iter jury or other tr		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Ponation 5 Other Specify: Green Mount Crematory 5	27/2010	Balto 1	MI
Baltimo permit. Pag Department Important:		21. Squature of Funeral Service Usersee 22. Name and Address of Facility	meral 1	tome, P.A.	·IIA
		Layer Vier 1222 W. North A	Ve.B6	21to, Md. 2	1216
Physician /M∈∈i∈al		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Sudden Unexplained Death In Infancial Cause /Final disease.			Approximate Interval Between Onset and Death
examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Су (БОБ1	.,	
		Sequentially list conditions, b.			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.			1
d d	Exami	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecute n and - tran		d.			
760, ficate be execute physician and the burial - tran	sician/Medical	AMENDED AMENDED AMENDED 3,27,28a-f,perME,G906,8/25/201	.0,Vt	23d. Date of delivery	
68760, certificate bo nding physic	an/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance	ancy	the same of the sa	Day Year
Box 687 e death certific the attending p	sici	1 Yes 2 No 9 Unknown 9 Unknown		1	
O. B nat the de ad by the etached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ires that signed	d by		1 Yes	2 No 3 Prob	ably 4 Unknown
rds requi	Completed		24a, Was a		topsy findings available ompletion of cause of
(eco	omp		perfor 1 ✓ Yes 2		s 2 No
tal Rection: The certificate	Bec	25. Was case referred to medical examiner?	only one)		
of Vital Records, g Physician: The law require then this certificate has been si meral director, page 2 should t	TO E	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursin	ng Home 5		
n of iding Pt.	in O	27. Manner of Death 1	_	ow injury occurred	
Division tal or Attendi at Director: /	icati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	unknowi 28f. Location (S	1 treet and Number or Ru	ral Route Number, Čity
Div pital or ours after	Certification	Suicide Sui	or Town, St	ate) 2836 Kent ore, Md. 21	tucky Ave.
Hos Fun Fun	ial C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause	e(s) and manner as state	ed.
To the within To the comple	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a		
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.	ME	29d. Date signed (Mor May 19, 2010	ıın, ⊅ay, rear)
		30. Name and address of person who completed cause of death (Item 23a)		, 70, 2010	
- Per		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimor	e, MD 21201		

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland		artment of Healt <i>tificate of Deatl</i>		lental Hy	giene Reg. No	ZUIU	16282
Physic	ian/	1. Decedent's Name (First, Middle, Last	*)				2. Date of De		v Year	3. Time of Death
Med	dical	Mary V. Smith	street and number)		4b. City, Town, or Location	on of Dooth	May	<u>23</u>	2010	8:00a M
Exam	mer	614 N. Bend Road		Baltimore					. County of Death Baltimor	e
Funera Directo		5. Social Security Number 6. Se 220–30–1709	x 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. rs Min.	8. Date of Bid (Month, Da Jan. 27	th ay, Year)	9. Birth Cour	place (State or Foreign offic) Tand
nd how at	٦,	Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Lo	cation				T.	10d. Inside City Limits
Maryla 28a-f s otified	Funeral Director	Maryland Baltimo	re		Baltimore					1 Yes 2 X No
th the	i D	10e, Street and Number			10f. Zip Code			-	tizen of What Cou	ntry?
ath wii ems 2: r must	uner	614 N. Bend Road	12. Was Decedent Ever in U.S.	13 \	21229 Vas Decedent of Hispanic	Origin2 (Spec	oify Ves or No-		USA	1
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at	۵	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		f Yes, specify Cuban, Mexic	ican, Puerto F			14. Race - Americ Black, White, Specify: Whit	etc.
15-(72 hou n "nat dedica	Completed	15. Decedent's Ed (Specify only highest grad		(Give I	lent's Usual Occupation kind of work done during m D NOT use retired)	nost of workin	ng	16b. K	ind of Business In	dustry
212 within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)		mbly Line Wo	rker		We	sting Ho	use
Viaryland 21 2 should be filed with h and Mental Hygier 7 is marked other traumatic event, th	To Be	17. Father's Name (First, Middle, Last)					(First, Middle,		Surname)	
Maryla 2 should be th and Men 27 is marke traumatic	ľ	Henry Clary 19a. Informant's Name/Relationship (Type)	pe, Print)	19b Mailin	g Address (Street and Num		Hurle	,	Town State Zin (Codel
Te, Marth and 2 st Health a item 27 is other tran	I	Larry L. Smith/ Hu	sband		. Bend Road,					
DOre ge 1 a nt of H r If itel	1	20a. Method of Disposition 1 🕱 Burial 2 🗆 Cremation 3 🗆	Removal from State cer		sition (Name of natory or other place)	1	ate		ocation - City or To	
Baltimor permit. Page 1 a Department of P Important: If its any injury or of	ااذ	4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License			Cemetery Name and Address of Fac	5/26/			imore, M	
any per G		Xunlessa		β0	Name and Address of Factorick	Road,	Catons	vill	ı нотw, e, Maryl	P.A. and 21228
Physician Medica	_	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	a Chronic Obs	struc	r the mode of dying, such			rest, SEA	s E	Approximate Interval Between et and Death
Examine	•		Due to (or as a consequen	nce of):						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a conseque	nce of):						
route be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	nce of):						
ertificat ding ph		IF FEMALE:	0- 16							
he death ce y the attend ched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnance 1 Live Birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Ectopic pregnancy Other (specify)			51 12	23d. Date of delive Month	ery Day Year
LIVISION OF VITAL RECORDS, F.O. BOX 05/10 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions cor	ntributing to death but not result	ing in the u	nderlying cause given in Pa	art i.				ne cause of death?
Hecords, The law requires cate has been sig	Completed						24a. Was autop perfo 1 Yes	osy	prior to cor	osy findings available mpletion of cause of
VICAI ysician: is certific director,	Be G	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		26. Place of D		1.			
OF V og Phy ter this neral d	te: To	27. Manner of Death	1 Inpatient 2 Ef 28a. Date of injury (Month, Day, Year)	R/Outpatien Bb. Time of injury	28c. Injury at work?	Nursing Hom 28	ne 5 A Resid Bd. Describe h		Other (Specify, occurred)
ttendir death. tor: Af the ful	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 ☐ Yes 2					
UNISION OF ital or Attending Purs after death. ral Director: After the in by the funera		4 Homicide determined	28e, Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	28	8f. Location (S City or Tow	street and n, State)	Number or Rural	Route Number,
the Hosp hin 24 hou the Fune mpleted fi	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurse	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my kn	nd/or investi	gation, in my opinion, death eath occurred at the time, da	occurred at that ate and place,	ne time, date a	nd place	and due to the car	ise(s) and manner stated
vit		29b. Signature and title of certifier Melusse 4	wolf CRN	P	29c. License number			29d. Date	e signed (Month, E	2010
		30. Name and address of person who co	DOLF, CENP	670	DI NOHA	WES.	ST.	Bal	timore	2010 NO 21204
Sta Regist	ate rar	31. Date filed (Month; Day, Year) —— XAY 25 20	32. Registrar's Signature		a chi li					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	State of Maryl	and / Dep	artment of	Health and	Mental H	ygie	ne		
			Registrar 1. Decedent's Name (First, Middle, L	ast)	Ce	rtificate of	Death		Reg.	No.	10	1628
	Physic		HELEN LOUISE SMITH	.431)				Date of I Month		Day	Year	3. Time of Death
_	Exam	lical iner	4a. Facility Name (if not institution, g	ve street and number)		41. 63		MAY	9,	^{Day} 2010	Teal	1626 p ^h
3			BALTIMORE WASHINGTO				or Location of Deat	th		4c. County	of Death ARUN	IDEI
	Funera		Social Security Number 6.	Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year		8. Date of E	Rinth	AININE		
	Directo	r	242.40.1983	1 □ M 2 XXF 78	Yrs.	Months Days	Hours Min.	(Month, I	Day, Yea	7) 32	Goun	
	and show	l a	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	action		1 1100 13	• 10	52		NCNC
	Aaryla Ba-f s tified	ect	MD ANNE		0.05, 10.1111 01 20						1	0d. Inside City Limits
	the la or 2	٥	10e. Street and Number	ARUNDEL		10f. Zip Code	EN BURNIE					1 Yes 2 XX
	s 23,	Funeral Director	1312 MEADOWVALE RD.				1060		10g.	Citizen of W	hat Coun	try?
	e filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Fu	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. \	Vas Decedent of H	ispanie Origina (S-	pecify Yes or No	<u></u>	USA 14. Race	Amorio	on Indian
36	after al", o	d by	1 Never Married 2 Married 3 Widowed 4XX Divorced	1 Yes 2 You	'	Yes, specify Cuba	in, Mexican, Puerti	o Rican, etc.)			, White, e	
9	hours latura ical E	Completed	15. Decedent's	Year or Dates.						Specify:	WHI	ΓE
215	n 72 an "r Med	lg l	(Specify only highest of Elementary/Seconday (0-12)	rade completed)	(Give I	ent's Usual Occup ind of work done of NOT use retired)	ation during most of wor	king	16b.	Kind of Bus	iness Ind	ustry
2	withi		8	College (1-4 or 5+)		US DRIVER			l no	100 OF 1	-011-	
nd	filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last,			J J J J J J J J J J J J J J J J J J J	18. Mother's Nan	ne (First, Middle	Maide	n Surname	-DUCA	TION A.A.Co.
2	should be filed within and Mental Hygiene. is marked other tha aumatic event, the N	-	LONNIE STONE					STONE	, 17107001	ii oumanie)		
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	Ιi	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a			er, City o	or Town, Sta	te. Zip Co	ode)
آ	and Heal em		DAVID EARL SMITH, SI 20a. Method of Disposition		996 7	th ST., GLE					· o, <u>_</u> , p o o	200)
no	age 1 ant of rt: If it		1 V KBurial 2 Cremation 2 A	MDamarral form Other	Place of Dispos	ition (Name of atory or other place		Date		Location - C	ity or Tow	vn, State
Ė	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 Other (Spec	(fy) NEW	HOLLYWO		MAY 1	3, 2010	L	.UMBERTO	N. NO	
B	Dep any onc		21. Signature of Funeral Service Licen K GREGARY	FANK MO114		Name and Addres	HOME P A					
			23a. Part 1. Poter the disease or com	plipations that saves date.	L 4.	6 CDAIN HW	V S CIE	AL DUDALLE	MD	21061		
i p	hysician/		Immediate Cause (Final						rest,			Approximate Interval Between
	Medical		disease or condition resulting in death)	a. Due to (or as a consec	Wence of	er en	rd St	age				Onset and Death
· de	Examiner		Sequentially list and distant	Mud	and 1	al d	1 leve h	'A) A				75
d.	- -	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of):	000	9-10/	Ort				5 95
Do !	executed an and rial-transi	xan	that initiated events	c	nph	1 Sem	9				1	404/2
_	ician	ial E	resulting in death) Last	Due to (or as a conseq							_	11
8760	incate be executed to physician and as the burial-transit	Medical		d	Typs	tens	nen					4045
89	5, 42		F FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy							
Вох	been signed by the attendin should be detached for use	icia	in the past 12 months?	1 Live Birth 2 Fets 4 Pregnant at time of	al death 3 🔲	Ectopic pregnancy Other (specify)			- 1	23d. Date o	,	
D. E	by the	hys	9 Unknown	9 LJ Unknown						Month	Da	ay Year
P.O.	gned se det	by E	art II. Other significant conditions co	ontributing to death but not res	sulting in the unc	erlying cause giver	n in Part I.	23e. Did to	bacco L	use contribut	te to the c	cause of death?
Records,	een si	ted	- ocet	Carcino	ma x	ing	(1.81				bly 4 Unknown
CO	has be	ng				U		24a. Was a				findings available
Division of Vital Records, P.O. Box 6. the Hospital or Attending Physician: The law requires that the death and	cate ha	Completed by Physician/						autop perfor	sy med?.	prior deat	to compl h?	letion of cause of
ital ician	certificate rector, pag	□	5. Was case referred to medical examiner?	1		26. Place	e of Death (Check	1 Yes	2 1 No	1 📙	Yes 2	No
Fhvs	ral dir	<u>ا ۾</u>	1 Yes 2 No 7. Manner of Death	lospital:			4 Nursing Hon		ence 6	Other (S	necifu)	
Division of Vital	er death. ector: After this by the funeral d	Certificate:	1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	t 2	8d. Describe ho			000.197	
iSic Atter	after death Director: /		3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	mo farm at a t		s 2 No					
Div	al Dir		4 LJ Homicide determined	building, etc. (Specify))	factory, office	2	8f. Location (St. City or Town	reet and , State)	Number or	Rural Rot	ute Number,
fospi	uner uner ed fill	Medical	9a. Certifier 1 Certifying Physical Examination 1 Medical Examination 1	cian: To the best of my knowle er: On the basis of examination	edge, death occ	ured at the time, da	ate and place and	due to the seve	2/2\	1		
the H	within 24 hours afte To the Funeral Dire completed filled in b		Only One) 3 L. Certifying Nurse	er: On the basis of examination Practioner: To the best of my	and/or investiga knowledge, deat	tion, in my opinion, on the tire	death occurred at the	he time, date an	d place,	and due to the	stated. he cause(s	s) and manner stated.
٥	o 2 wit	29	b. Signature and title of certifier	er		29c. License nu	ımber	and due to the	9d. Date	and manner signed (Mo	as stated onth, Day,	1.
						D141			5	110/10	,	
	3	30	. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print	DALJIT	5. SAW	HNEY				
	State	L	Date filed (Month, Day, Year)	owers year	1 Jur	nie n	ld 210	67				
	Registra		MAY 25 2010	32. Registrar's Signatu	ıre							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 **2** M 2 □ F Conth. Day, Year) 2 Country) Director Jsual Residence of Decedent Show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 es 2 🗌 No 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? Yes 2 No No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Be Father's Name (First, Middle, Last other's Name (First, Middle, Maiden Surna and Mental ပ္ Page 1 and 2 should be ment of Health and Menta permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Signatur of Funeral Se vice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 40 Onset and Double Immediate Cause (Final Ph.sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause in the Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to lor as a considuence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last pe 68760 Hospital or Attending Physician; The law requires that the death certificate IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregna
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 this certificate 1 Tes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, to 25. Was case referred to medical Thomas of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 120396 30 Name and address of person who completed cause of death (Item 23a) (Type Print) Calvert St 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

1

			_ State	e of Marylan	d / Depa		Health and	-	/giene	2010	16295
	Physicia		Registrar Decedent's Name (First, Middle, Last) John Daniel Sutak			incate UI	Deaul	2. Date of D		2010 Year	3. Time of Death 10:00 P.M
	Medic Examin		4a. Facility Name (If not institution, give street and Upper Chesapeake Medic		r		or Location of Deat		4c.	County of Death	110.00 1.
	Funeral Director		5. Social Security Number 6. Sex 112-05-7156	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs	(Month, D	rth av. Year)		place (State or Foreign
	/land f show d at	tor	Usual Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
	the Mary a or 28a-	I Director	Maryland Harford 10e. Street and Number		Bel A	ir 10f. Zip Code			10g. Citi	izen of What Cou	1 Yes 27 No
	ath with ems 23a r must b	Funeral	1411 Prospect Mill I	Road ecedent Ever in U.S	S. 13. V	21015	Hispanic Origin? (S			ed State	
9000	go 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The of Health and Mental Hygiene. Or other traumatic event, the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 1 ☐ Y Married 3 ☐ Widowed 4 ☐ Divorced Armec	Forces? es 2xxxNo	If	Yes, specify Cub	an, Mexican, Puer	o Rican, etc.)		Black, White, Specify: Whit	etc.
70 Mandand 2424E 0026	nin 72 horae. Han "nate Medica	Completed		ted) e (1-4 or 5+)	(Give k life, DC	NOT use retired	during most of wo	rking	16b. Kir	nd of Business In	dustry
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2	yican Ild be fi Mental narked atic ev	잍	Julius Sutak				I .	et Slani			
	nd 2 shouealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Helen Sutak / Wife				and Number or Ru t Mill Ro			, , ,	,
5. J 23	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition 1 ☐ Burial ②□Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. F	Place of Disposemetery, cremotery, atory or other pla ieral Ch	aper:	21, 10_		cation - City or To	own, State Maryland	
C. C.	permit. Departimont any inj.		21. Signatur A Funeral Service ticensee	2	22. Ex	Name and Address	ess of Facility	el & Cr	emati	ion Serv	ice-BelAir
<i>j</i> -	Pnysician/		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one date or Immediate Cause (Final	at caused the death each line.	h. Do not ente	r the mode of dyi	ng, such as cardiad	or respiratory a	rrest,	ary rane	Approximate Interval Between Onset and Death
2010	Medical Examiner		disease or condition resulting in death) a. Due	to (or as a consequ	uence of):	A DATE		rome			Day 1
- 55		ner	Sequentially list conditions, if any, leading to immediate	to (or as a consequ	Aitc	Ausc	2120				Day 1
S S	be executed sician and burial-transit	cal Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due	to (or as a consequ		RENAL	failur	દ		-	Day 1
Σ	cate be e	edical	d								
D.0.1).	To the Hospital or Attanding Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the laws.		in the past 12 months?	outcome of pregna ive Birth 2 Feta regnant at time of c nknown	al death 3 🗌	Ectopic pregnan Other (specify)	су		2	23d. Date of delive Month	ery Day Year
٥	es that the signed by be detail	by Pł	Part II. Other significant conditions contributing t		_		iven in Part I.			w/*	ne cause of death?
	w requir	pletec	Cororry	711-61	9	3 (17)		24a. Was	an	24b. Were auto	psy findings available
Janie Janie	The la	Com							psy ormed? 2 No	death?	mpletion of cause of
	ysician is certif director	lo Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☑ Inpatient 2 □	ER/Outpatient	Oth	lace of Death (Che ner: 4 \sum Nursing F		dence 6	Other (Specify	1
John	nding Ph ath. r: After th e funeral	icate:	27. Manner of Death 28a. Da	ate of injury lonth, Day, Year)	28b. Time of injury	28c. Inju	ry at	28d. Describe			,
Jak, John Daniel Division of Vital Bocards	al or Atte s after de s l Directo ed in by th	l Certif		ace of Injury - At ho ilding, etc. (Specify,		et, factory, office		28f. Location (City or Tov		Number or Rural	Route Number,
4mC	ne Hospit in 24 hour ne Funer's pleted fills	Medical Certificate:	29a. Certifier (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination	and/or investi-	gation, in my opini	on, death occurred	at the time, date a	and place, a	and due to the car	use(s) and manner stated.
	To the to the com		29b. Signature and title of certifie	mo		29c. Licens	e number 66342		29d. Date	e signed (Month, I	
	Ve		30. Name and address of person who completed c			int) Kapi	Kumar 13=1-	Pate	m.		
	Stat Registra	e ır		. Registrar's Signat		barkel	1321- 1	1162	, v	٦,٠٠	· t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5.557 M MATH 2 Pay 20 Year Kihong Stone-Chaney Medical 4a. Facility Name (if not institution, give street and number) 4c County of . 4b. City. Town, or Location of Death **Examiner** County of Death BOTTIMORE LOASHINGTON MEDICAL LIZMIE N UNDE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Korea** 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Days Hours Min. March 22 Director 269-74-3975 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No <u>Maryland</u> Anne Arundel Odenton 0e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 811 Lamoka Drive 21113 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Divorced Specify: Korean Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ Oak In Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>George E. Chaney, Husband</u> 811 Lamoka Drive, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2010 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda 22. Name and Address of Facility Cremation Society of Maryland, Inc. Heaston ded 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it and heading lower detections. Enter Underlying Cause (Disease or injury that in the detection of the conditions). Dire to (or as a monsequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been si should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed Yes 2 this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 25149 Name and address of person who completed cause of death (Item 23a) (Type, Print) MOS MARSH 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 02 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 46 Boone Trail Severna Park Anne Arundel 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Feb. 5**, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 53 Director 005-60-6341 1957 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r items 23a or 28a-f shor 1 ☐ Yes 2 X No Directo Maryland | Anne Arundel Severna Park the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 Boone Trail 21146 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 X Yes 2 □ Nd 1975 If Yes, Give Year or Dates: 1997 1 Never Married 2 Married ·o. Maryland 21215-0036 1 ☐ Yes 2X No Specify: 7 Is marked other than "natural", o traumatic event, the Medical Exam δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Senior Chief U.S. Navy 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Ε. Smith Jeannette E. DeMille 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 li other tra Smith/ Wife Suzanne 46 Boone Trail, Severna Park, Maryland 21146 altimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages Department of Important; If its any injury or o ŏ 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/22/2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ance disease or condition resulting in death) /Medical Due to (or as a prosequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit death certificate be execu Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ icate has been siç 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕽 🗖 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

Registrar's Signature

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010^{Year} James Vincent Simonette May 9:45 P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Medical Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) WVA Months Days Hours July 23 236-20-0085 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 😾 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Gurteen Ct. #202 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced Year or Dates. 42-47 Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) High School Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Simonette Margaret Cacciatore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Gurteen Ct. #202, Timonium, MD 21093 Lila L. Simonette/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/26/10 cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fundal Service Michael Q 23a. Part 1. Fater the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MYOCARDIA Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

MD

Examiner

Funeral

Director

23a or 28a-f show

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

4 Hospital or Attending Physician: The law requires that the death certificate be executed. 24 hours after death.

Funeral Director: After this certificate has been signed by the attendion and the attendion a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran

124 State

To the within 2

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examine Harry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No IN SUFFICIENCY 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: /2 ₽ No Other: 1 Tes Certificate: To 1 Inpatient 2 MER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Carr, M.D. 1 Texas Station Ct., Suite 210, Timonium, MD 21093

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of He tificate of De	ealth and Mental I eath	Hygiene Reg. No.20	0 16289
	Physicia		1. Decedent's Name (First, Middle, La Natas ha	st)	SK	oriK	2. Date o		3. Time of Death
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-	Xu		The Johns Hopkins H			Baltimore C		f Dieth C). Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. 212–25–3500	Sex 7. Age (In y	rs. last birthday) 43 Yrs.		If Under 24 Hrs. Hours Min. 8. Date or (Month Sep.	13, 1966 N	Country) 101dova
	nand now		Usual Residence of Decedent 10a. State 10b. County	100.	City, Town or Lo	cation			10d. Inside City Limits
	Ba-f sh	Director	Maryland Balti	more	Reist	erstown			1 ☐ Yes 2XXVo
	death with the Maryland ms 23a or 28a-f show must be notified at		10e. Street and Number	Lano		10f. Zip-Code 2113	86	10g Citizen of What United S	
	death	Funeral	402 Sacred Heart 11. Marital Status	12. Was Decedent Ever in	1 U.S. 13.		panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	Of Ameri	American Indian, White, etc.
980	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes No If Yes, Give Year or Dates:			Specify:	Specify:	White
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ylar		10 E	Ivan Skorik		1		Luba Vashche		7:- C-d-)
Maryland	2 s an is		19a. Informant's Name/Relationship			_	nd Number or Rural Route N		
	s 1 and f Health fem 27 other to	ŀ	Anatoly Gaevsky 20a. Method of Disposition	20		osition (Name of matory or other place)			
mo	60 O		XXBurial 2 Cremation 3 Donation 5 Other (Spec	fy) A	11 Saint	s Cemeter	y 2010	Reisters	town, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Furgeral Service Pica	M.			of Facility Eckhardt erstown Road,		hapel, P.A. 11s, MD 21117
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1	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):		U		
	400	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a con	Sequence uty:		·		
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Box	e death certific the attending p hed for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date Monti	·
ds, P.O.	law requires that the decase been signed by the at a should be detached?	by	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause give		Did tobacco use contrib	oute to the cause of death?
of Vital Records,	aw require s been sig 2 should	Completed						Was an 24b. We autopsy pri	ere autopsy findings available for to completion of cause of
- Re	The lar	Som					1 🗆 Y	performed? de	eath? Yes 2 No
Vita	Physician: The I this certificate ha	Be	25. Was case referred to medical examiner?	Hospital:	0 7 500 1111	Other	26. Place of Death (Check o	_	(Coopie)
of	F in la	<u>و</u> ::	1 X Yes 2 □ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier			ribe how injury occurred	
sion	Attending For death. Sector: After the funer by the funer.	atio	Natural 5 Pending investigation			M 1 □ Ye	es 2 No		
Division	l or Atte after de Directo d in by t	Certification:	3 Suicide 6 Could not determine	28e. Place of injury - A building, etc. (Sp		eet, factory, office		ion (Street and Number r Town, State)	r or Rural Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	ledical C	29a. Certifier (check only one)	hysician: To the best of my aminer: On the basis of exar and manner stated.	knowledge, deat nination and/or in	h occurred at the time evestigation, in my opi	e, date and place, and due to inion, death occurred at the	o the cause(s) and man time, date and place, a	ner as stated. nd due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier		10	29c. License r		29d. Date signed	(Month, Day, Year)
			1743	N N	10	RES	5-000	May 2	2,2010
_	30		30. Name and address of person when your attention with the same and address of person when the same and address of person and address of person and address of person and address of person address of person and address of person	Mar Kouda	ya mo		600 North	Wolfe St, Ball	timore, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2.5 201	22. Registrar's S	d. Jan	Rad			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ May Month E1mer 20 2010Sakowski 2:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6868 Baltimore & Annapolis Blvd Linthicum Anne Arundel Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 90 Days May 30, Year) 1919 1 XM 2 1 215-05-5112 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any injury. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6868 Baltimore Annapolis Blvd. USA 21090 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Settling Burner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Donna DuPuis/ daughter 312 Silky Oak Court Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MD Vets Cemetery 5/26/2010 Crownsville, MD 21. Signatur of uneral Savere Line Rec 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave, SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Ceirlialiscolur Disease equentially list conditions. Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be deteched for use as the burlar-transit completed filled in by the funeral director, page 2 should be deteched for use as the burla-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 □ Yes ∠∟ 9 □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Valvolar Heart Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed21 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 39660 Kenut Deut Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Baltimore

MIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MPATY 20°TO SHACKMAN 5.50 PM SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Days Hours 1070771920 NY Director 220-12-7347 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 X No MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 MONTROSE ROAD USA 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Arroyed Forces? 1 Never Married 2 Married Black, White, etc. ò þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) **ADMINISTRATION** DEPARTMENT OF DEFENSE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 DAVID SHACKMAN ELSIE SUSSKIND traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i JOAN ASKIN / SISTER 3704 N. CHARLES ST., #1204, BALTIMORE, MD 21218 other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 X Burial 2 Cremation 3 Removal from State WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 05/23/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Li 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ations that cause art 1. Enter the diseas shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ EMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Completed by Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death s been signed by the s should be detached 1 ☐ Yes 2 € 9 ☐ Unknown Linknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has 1 Yes 2 No Yes 2 HNo Division of Vital Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending F 124 hours after death. In Funeral Director: After bleted filled in by the funer. 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061096 05/22/2010

Registrar DHMH 17 Rev 7/2009

State

Tousha

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USHA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPALLI

6121 MONTROSE ROAD

ROCKVILLE, MD 20852

HILLDA SMITH Dr Linowon as

			Please Type or Print in Black Indelible Ink. En	•	
		•	1 - State of Maryland / Department of Health Certificate of Death	,	/giene Reg. No. 2010 16292
	Physicia Medic			2. Date of De Month	Day Year 23 2010 9:51 A M
	Examin	er	4a. Facility Name (if not institution, give street and number) SINAI HOSPITAL OF BACTIMORE 4b. City, Town, or Location BACTIMO		4c. County of Death NA
	Funeral Director		5. Social Security Number 214-26-0384 6. Sex 1 M 2XIXF 7. Age (in yrs. last birthday) 1 If Under 1 Year 1 If Under 1 Yea	ler 24 Hrs. 8. Date of Bi	9. Birthplace (State or Foreign Country) MD
	laryland 3a-f show iffied at.	ector	10.0		10d. Inside City Limits X Yes 2 □ No
	s 23a or 20 ust be not	Funeral Director	10e. Street and Number 10f. Zip Code 2801 Rayner Avenue 21216		10g, Citizen of What Country? USA
9036	is filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.				14. Race - American Indian, Black, White, etc. African Specify: American
21215-0036	ed within 72 hou Hygiene. other than "natu ent, the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 7 th Grade 15. Decedent's Usual Occupation (Give kind of work done during model life. DO NOT use retired) Housewife	ost of working	16b. Kind of Business Industry Various trades
Maryland 2	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last)	other's Name (First, Middle $z\!\in\!1$	
	1 and 2 should be of Health and Ment fitem 27 is marker rother traumatic e			le Street	Baltimore, MD 21216
Baltimore,	t. Page tment rtant: I		X X Burial 2	06-02-10	20c. Location - City or Town, State Owings Mills, MD
Ba	permi Depar Impor any ir	la a		or Street	uneral Home P.A. Baltimore,MD 21217
	Priysician/ Medical	0.0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RESPIRATORY DIS		
	Examiner	er	Due to (or as a consequence oi).		
ф.	e executed cian and urial-transit	Examine	the state of the s		
09	ate be ex ohysician the buria	ا≂ا			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within Euhours after death certificate be within Euhours after death. To the Euhours after death after this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 1 Unknown 1 Unknown 1 Ves 2 Ves 2 Ves 3 Ves 4 Ves	-	23d. Date of delivery Month Day Year
Division of Vital Records, P.O.	quires that the signed by all the deta			1 🗆	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Recor	The law recate has been page 2 sho	Completed by	Storge III carval decubitus ulces, And of imonic disease	perf	
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner?	eath (Check only one)	
on of \	nding Phy ath. r. After this ie funeral d	Certificate: To	Imparion CE Envertage of CE 551	28d. Describe	idence 6 ☐ Other (Specify) how injury occurred
Division	tal or Atters after de al Directo ed in by the			28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
	the Hospi nin 24 hou the Funer npleted fill	Medical		occurred at the time, date	and place, and due to the cause(s) and manner stated.
			29b. Signature and title of certifier AMIT RITISE 29c. License number Rich -		29d. Date signed (Month, Day, Year) MAY - 23 - 2010
_	Z		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIT BHISE MBBS, SINA! HOSPITAL OF BA		MD-21215
	Sta Registra				
DHI	MH 17 Rev 7/20	009			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 2010 10:42 A M Physician/ Mary Catherine S. Saltzgaver Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson 8. Date of Birth Month, Day, Year Aug 5, 1926 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Maryland **Funeral** Months Davs Hours Min. 1 □ M 2 😾 F 83 Director 215-20-9061 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a, State I Hygiene. other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at Director 1X☐ Yes 2 ☐ No Baltimore N/A <u>Maryland</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21239 1903 Lydonlea Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after death 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Yes Give 3 🕅 Widowed 4 🗆 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Secretary of Health and Mental Hygie If item 27 is marked other r other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Bertie E. Lowe Charles E. Sies Sr. Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7413 Varnum Street Landover Hills, Maryland 20784 Verona Juhasz, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or other place) 1 Burial 2 Caremation 3 Removal from State Department o Important: If any injury or once. ō 05/25/10 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licenses/Thomas Gregor 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Preet and Death Immediate Cause (Final the Physician/ ancien disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes To Be Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 [1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 No Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manner of Death Certificate: After work?
1 Yes 2 No 5 Pending Investigation Accident after death 28f. Location (Street and Number or Rural Route Number, 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 To the 29b. Signature and title of certifier no completed cause of death (Item 23a) (Type, Print) HARLES ST. NEUSSA J 31. Date filed (Month, Day, Year) State back Registrar

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ada Smith 2010 7:20 ам Medical 4a. Facility Name (if not institution, give street and number)
4808 Clifton Avenue 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death Social Security Number 8. Date of Birth (Month, Day, Yo June 10, 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) **Funeral** Days 1 □ M 2**X** F 212-34-3522 83 Director **June** 1926 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important, If item 27 is marked other than "natural" any injury or other traumatic events once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ★ Yes 2 □ No 10f. Zip Code 21207 10e. Street and Number 4808 Clifton Avenue 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛂 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Black 3[™] Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary Bell Walker ပ္ Archie Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4808 Clifton Avenue, Baltimore, MD 21207 Yvonne Smith Savoy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 5/25/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22. Name and Address of Facility remation Services Baltimore, MD 21203 PO Box 1413, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Between nd Death Immediate Cause (Final sestions Ph sician/ 00 2000 disease or condition Medical resulting in death) Due to (or as a con uence of) Examiner 2000 Sequentially list conditions, Physician/Medical Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit 2000 Due to (or as a consequence of): resulting in death) Last 2 Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 🗌 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? after death. 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title ertifier 201

State Registrar Name and address

31. Date filed Month, Day, Year)

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of person who completed cause of death (Item 23a) (Type, Print)

WE

32. Registra 's Signature

oce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Marylan		tificate of L			gien Reg. N	2010	6293
Physician/		I. Decedent's Name (First, Middle, La	Majchrzak Ta	avlor			2. Date of Dea	ath		3. Time of Death
Medical Examiner	ı	a. Facility Name (if not institution, give	street and number)	ayıoı	4b. City, Town, or	Location of Death	_May_	\neg	22, 201(c. County of Deat	h
	ı	Gilchrist Co		et hirthday)	Tows	SON I If Under 24 Hrs.	8. Date of Birt		Baltin	
Funeral Director	L	213-94-9858 1 July 1 Residence of Decedent	□ M 2 🛛 F 4 3		Months Days	Hours Min.	(Month, Da	y, Year) 10,1	Cot	hplace (State or Foreign intro) yland
ne Maryland or 28a-f show notified at	- 1-	Oa. State MD 10b. County Harfo	ord 10c. City	, Town or Loc Bel A:	ation ir					10d. Inside City Limits 1 ☐ Yes 2X No
tems 23a or ter must be n		Oe. Street and Number 2511 Cool Spi	ing Road		10f. Zip Code 210	15		10g. C	U.S . A .	untry?
°		Marital Status Never Married 2 ☐ Married Widowed 4 ※ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1	☐ Yes 2 🌠 No		cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by		15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 1 2	ducation ade completed) College (1-4 or 5+)	(Give k life. DC	ent's Usual Occupi ind of work done of NOT use retired) retary	ation furing most of workii	ng		Kind of Business MAuto	ndustry Motives
ore, Maryland 2 e 1 and 2 should be filed wit of Heath and Mental Hygie if item 27 is marked other or other traumatic event, the		7. Father's Name (First, Middle, Last) George Majchr	zak			18. Mother's Name Cathe	(First, Middle, rine P			
		19a. Informant's Name/Relationship (1 George Majchr		19b. Mailin 2511	g Address (Street a	end Number or Rura pring Roa	Route Number ad, Be	r, City o	or Town, State, Zip i r, MD 2	1 0 1 5
Baltimore, oemit. Page 1 and Department of Hea Department of Hea Mportant: If item any injury or other sonce.	2	0a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State EV	emetery crem ans F ape I –	sition (Name of latory or other plac UPETAL Bel Air	e) May 201	0	F	Location - City or rest Hi	11, MD
Baltimo permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Licen:	ELCUM	0	ow Hari	ord Road	ı, Par	KVL	emation lle, MD	Services 21234
h, sician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final discusse or condition sulting in death)	plications that caused the death ine cause on each line. a. Due to (or as a consequ	Aic	r the mode of dying		r respiratory arr	rest,		Approximate Interval Between Onset and Death
e executed aian and unial-transit		Sequentially list conditions, if any leads to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): C. — Due to (or as a consequence of):							
Box 68 death certifi the attending ed for use a rsician/M		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Ye ar
Is, P.O. Juries that the signed by to the detach d		Part II. Other significant conditions o	ontributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director. After this certificate has t een sig completed filled in by the funeral director, page 2 should b Medical Certificate: To Be Completed I	-						24a. Was a autop perfo	SV	24b. Were aut prior to death?	opsy findings available ompletion of cause of
ician: Tector, pector, p	2	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Check	only one)			1
of Vige Physical Physical Character (1972)		7. Manner of Death	1 ☐ Inpatient 2 ☐ I 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury work	4 ☐ Nursing Hor	me 5 Resid		6 Other (Special occurred)	fy) NO CPI @
ivision of or Attending P after death. Director: After the by the funeral in by the funerance Certificate:		1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined		ne, farm, stre	M 1 🗆	Yes 2 No	28f. Location (S City or Tow		nd Number or Rur	al Route Number,
Direction of the Hospital of the Funeral Displeted filled i			sícian: To the best of my knowle							
the Hothin 24 thin 24 the Fu			iner: On the basis of examination se Practioner: To the best of my		eath occurred at the		e, and due to the	cause	(s) and manner as	stated.
		Meran	rus		03	830	2	M	ate signed (Month	2-0/0
0	(Nameland address of person who	completed cause of death (Item	23a) (Type, Pi	6701	N. Cus	mas	2	r Pan	USON MD
State Registrar	3	1. Date filed (Month, Day, Year) 20	3. Registrar's Signat	fa	RI					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2010 5:00 P. M Coralie Ullrich 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Villa <u>Assumpta</u> Baltimore Baltimore 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months July 27, Year 913 Maryland 96 215-58-1242 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 1 🗌 Yes 2 😾 No Baltimore <u>Maryland</u> Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 N. Charles Street U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor vears Biology 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madalyne Frederick R. Ullrich Atchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Patricia Glinka, S.S.N.D N. Charles Street Baltimore, Maryland 21212 6401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 \overline{X} Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) College of Notre Dame Cem. 5-27-10 Baltimore, Maryland Signature of Funeral Service Licensee 2. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary 21212 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line.

Physician/ Medical [/]Examiner

as the burial-transi

detached

the attending physician and

Physician/

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Director

Funeral

Completed by

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Examiner

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event.

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Examiner Certificate: To Be Completed by Physician/Medical n signed by ti

To the Hospital or Attending Physician: The law requires that the death certificate be executed

nas

Director: After this certificate |

within 24 hours after To the Funeral Direct

completed filled in by the funeral director,

Medical

29a. Certifier

(Check only one

GINO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death)	a. Due to (or as a consequenc		ncer			riset and Death
Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. — Due to (or as a consequence	e Utj.				
Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequenc	e of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de: 4 Pregnant at time of death 9 Unknown				23d. Date of delivery Month Da	
Part II. Other significant conditions	contributing to death but not resultin	g in the underlying	cause given in Part I.		o use contribute to the	
				24a. Was an autopsy performed?	death?	letion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)		
1 Yes 2 No	Hospital:	Outpatient 3 🗆 🛭	OA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj	iury occurred	
3 Suicide 6 Could not 4 Homicide determine		farm, street, facto	y, office	28f. Location (Street a	and Number or Rural Ro	oute Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Luis Fernando Viladegut Physician/ Day 19 :29 PM May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-08-6533 1X M 2 □ F Months Days Hours (Month, Day, Year) Director 43 Aug. Peru Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Potomac 1 Yes 2 No 10e. Street and Number 11308 Gainsborough Road 10f. Zip Code 20854 ö 10g. Citizen of What Country? 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 0 1 X Never Married 2 Married þ Maryland 21215-0036 1 □Xyes 2 □ No Specify: Peruvian res, Give US Army Year or Dates. White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Software Developer Department of Commerce Be 18. Mother's Name (First, Middle, Maiden Surname) Angel Viladequt မ Rosa Patino - Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14674 Keeneland Circle, North Potomac, MD 20878 Angel A. Viladegut / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State remetery, crematory or other place)
Final Journey Crem. 1 🔲 Burial 2 🔀 Cremation 3 🗌 Removal from State 5/21/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 Dorota Marshall llaisha 11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Combined Variable Immunodeficiency Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Malnutrition Sequentially list conditions, Due to for as a sonsequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Malabsorption sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical The law requires that the death certificate be for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 20 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, Completed № No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🔀 No မ 1 🗌 Yes 1 Mnpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death 2 Accident Investigation 6 Could not be the within 24 hours after deat To the Funeral Director; Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nly one Certifying Nurse Practioner: To the best of my knowledge, death ancien at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
May 19, 2010 D 0063195 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Viladeg

racks

Steven Willis, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		riease	State of Mar		Department of I				_egible.	
		for State Registrar	State of Ivial	ylanu / i	Certificate of			Reg. No.	2010	16298
		Decedent's Name (First, Middle, L.)	ast)	_	1 1	1	2. Date of Dea	ath		3. Time of Death
Physicia /Medic			Jero	me	Woisz	yns ci	Month	/ 2 3	Year 2 0/ 0	0 3:05PM
Examin		4a. Facility Name (If not institution, g	live street and number)	0 1	4b. City, Town,	or Location of Death		4c.	County of Deat	h
		St-C-lizabeth	Nursing 1	Cent	BALTIMORI		T = =			
Funeral		,	Sex 7/Age	(In yrs. last bi	yrs. H Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da DEC 21,	v. Year)	9. Birt Co	hplace (State or Foreign untry) PA
Director		182.12.0899 Usual Residence of Decedent	^^	00			DEC 21,	1321		rn .
ryland	_	10a. State 10b. County	1	10c. City, Tow	vn or Location					10d. Inside City Limits
Ba-f s	ecto	PA ALLEGHEN	1Y	PIT	TSBURG, CASTLE	SHANNON BOR				1 ☐ Yes 2 ☐ No
with the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
eath i	eral	4145 MATHILDA STREET	12. Was Decedent Ev	er in U.S.	1523		ecify Yes or No	- 1	USA 14. Race - Ame	rican Indian.
ifter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?		13. Was Decedent of If Yes, specify Cub		Rican, etc.)		Black, White	
ours a	d by	3 ₩Widowed 4 □ Divorced	MY es, Give Year or Dates:		1 □ Yes 2MNo	Specify:		Specify: WHITE		
72 h "natu	letec	15. Decedent's (Specify only highest g	Education grade completed)	16a	 Decedent's Usual Occu (Give kind of work done 	during most of work	ring	16b. Kir	nd of Business/	Industry
within ene. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		`life. DO NOT use retire LABORER	ea)			WEST I NGHO	OUSE ELECTRIC
filed I Hygi other ent, I	Be Co	17. Father's Name (First, Middle, La.	st)	<u> </u>		18. Mother's Nam	e (First, Middle,	, Maiden i	Surname)	
Aenta Aenta rked tic ev	To B	KASIMIR WOJSZYNSKI	ı			LAURA FI	LIP			
and N		19a. Informant's Name/Relationship	(Type. Print)	198	b. Mailing Address (Stree	t and Number or Ru	ral Route Numb	er, City or	Town, State, Z	Zip Code)
and 3 lealth m 27 her tr		JOSEPH A. WOJSZYNS	K1		5612 POOLITTLE					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mailrel Expriment must be refilled at once.		20a. Method of Disposition		1	of Disposition (Name of ery, crematory or other pla		Date		cation - City or	
nit. Pa artmei ortant injury		4 ☐ Donation 5 ☐ Other (Spec	ensae :	SAINT A	ANN CEMETERY	5.29.2			TSBURGH,	
permit. Departr Importa any inju		1 may M		M01148	FINK FUNERAL 426 CRAIN HWY	HOME, P.A.	t/a MARYL	AND M	ORTUARY S	SUPPORT
		K CREGORX FINK	mp ications that caused the caused the cause on each line.							Approximate Interval Between
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/Medical		resulting in death)	Due to (or as a	consequence			710000		-	
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ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to tor as a	consequence	of):	u dis	ase			
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ath ce ttendi or use	an	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		h 3 ☐ Ectopic pregnan	су		2	23d. Date of del Month	livery Day Year
ne deg the a	Physician/Med	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death	5 ☐ Other (specify) _				WOTH	Day Four
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clan: ertifica ctor, p	Be	25. Was case referred to medical examiner?				26. Place of Deal		/V		
Physic this c		1☐ Yes 2ДNo			outpatient 3 100A		ome 5 Resi			ecify)
ding I	ion:	27. Manner of Death ↑ Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day,		Time of linjury 28c. Inju Wo	ıryat rk?]Yes 2∐No	28d. Describe l	how injury	/ occurred	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. When the Funeral Director: Adher this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total director.			Physician: To the best of aminer: On the basis of e							
the Ithin 24 the F	Medical	one)	and manner state							
5 7 × 0		29b. Signature and title of certifier	That	1 pm	2ac. Licen	se number		AA A	e signed (Mont	70/0
		30. Name and address of person wh	o completed cause of dea	ath (Item 23a)	(Type, Print)	33571		10.00	y 27	, 2010
10		Ming Vimo	3320 15-01	nson	Ave. 15a	timore	Ma	y lo	md.	2122/
Sta	te	31. Date filed (Montl, Day, Year)	32. Registrar	's Signature	A booked		,	/		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 18. Wang Heiming 6:07 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Jan. 27, 1921 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F China Director 231-61-9863 89 Usual Residence of Decedent Show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location 10d, Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Fairfax Herndon VΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13115 Bradley Farm Drive 20171 China 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Chinese "natural", 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Fabric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shi Xun Wang Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maocheng Wang - Son 3115 Bradley Farm Drive, Herndon, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State Mount Hebron Cemetery 05-27-2010 Winchester, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Si tu e f Funeral Service Licensee 22. Name and Address of Facility Jones Funeral Home 228 S. Pleasant Valley Road, Winchester, VA 23a. Þart 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) 4 Wes Medical Due to (or as a consequence of) **Examiner** neumon Sequentially list conditions. Examine if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 certificate I Yes 2 XN 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital 24 hours a Funeral L Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner 1. It is best of my browledge and the inner estated (Check within 2 To the I the of certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ٥ D-18895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1610 CARROLL AVE, Ste 340, TAKEMA PARK 1410 20912

Registrar DHMH 17 Rev 7/2009

State

OB ARAIL

31. Date filed (Month, Day, Year,

CARIM

10-03897 Justin Hayes Wilson

lease Type or Print in Black Indelible Ink. Ensure All Copi	es Are Legible) .	
State of Maryland / Department of Health and Mental F	lygiene	2010	6300
Certificate of Death	Reg. No.		
me (First, Middle,Last)	2. Date of Death	V	3. Time of Death

		1- For State Registrar	Čei	rtificate c	of Death		F	Reg. No.			
Physic		Decedent's Name (First, Middle,Last)	-				2. Date of Dea Month		3. Time of Death		
edical Exam	iner	Justin H. Wilson 4a. Facility Name (if not institution, give street and number)			4b. City, Town,	or Location of D	May 21, 2	4c. County of	" 2046 hrs		
		Upper Chesapeake Medical Center			Bel Air	or Ecoditori of B	0001	Harford	o beaut		
Funeral			e (In yrs. i	ast birthday)	If Under 1 Ye			irth(MM/DD/YYYY	9. Birthplace (State or Foreign		
Director		217-61-5191 _{12M 2[F]}		8 Yr	s. Months Da	ays Hours	Aug. 8	3,2001	Country) MD		
any	1	Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Loca	ation				10d. Inside City Limits		
*		MD Harford	roo. Oity,		ngdon				1 Yes 2 No		
. Maryland r 28a-f show	Director	10e, Street and Number	-		10f. Zip Code		T.	10g. Citizen of Wh			
the M Sa or 2		1220 Splashing Brook	Dri	ve	210	09		USA			
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Manal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?			as Decedent of H		(Specify Yes or No erto Rican, etc.)	o- 14. Race White	- American Indian, Black,		
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urs afi tural' amine	d by	or Dates: 15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decede	nt's Usual Occup	ation (Give kind	of work done	Specify: 16b. Kind of Bu			
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MD 21215-0036 12 should be filed within 77 th and Mental Hygiene. 27 is marked other than tumatic event, the Medical	Be C	Kris Wilson					ame (First, Middle, ce Chinn)		
212 ould b 1 Ment 5 mark ic ever	ם	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stre		or Rural Route Nur		n, State, Zip Code)		
MD d 2 sho lith and in 27 is		Kris Wilson / father							Abingdon MD		
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	te C	crematory or o		· 1	Date		City or Town, State		
altimore, mit. Pages I ar spartment of Her portant: If ite lury or other tr		4 Donation 5 Other Specify:	Ba	-	Cremat		5/28/10		more MD		
Baltimo permit. Page Department o Important:		21. Signifure of Funera Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto									
Physician	Z 7	23a. Pert I. Enter the disease complications that caused	the death.	. Do not enter	the mode of dying	<u>IV</u> FUI g, such as cardia	ac or respiratory arr	OME OI I rest, shock, or hea	Approximate Interval		
/Medi Examiner	66 V	failure. List only one cause on each line. Between									
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760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED									
8760, ificate be ig physic	_	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	e of pregr		etal death 3	Ectopic pre	gnancy	23d. Date of o	delivery Day Year		
that the death certifined by the attending detached for use as the	Physician	past 12 months?	time of de	ath =	ther (Specify)			1	Suy Four		
. Bc he dea y the a	hys	Part II. Other significant conditions contributing to death	hut not so	aultina in the	undarkina neven	niven in Deat I	220 Did to	abassa uga santrib	oute to the cause of death?		
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	<u>چ</u>	Tarric Ottor Significant Containing to death	bat not re	sadding in the	underlying cause	given in Fait i.		s 2 No 3			
ds, require been si	Completed						24a. Was		/ere autopsy findings available		
ecol	ם	·					_ autop perfo 1 ✓ Yes	rmed? de	rior to completion of cause of eath?		
n: The		25. Was case referred to medical			26.Plac	e of Death (Che		2 NO 1	Yes 2 No		
Vita hysicis this ce	To Be	examiner? 1 • Yes 2 No Hospital: 1 Inpatier	nt 2 🗸	ER/Outpatien	t 3 DOA	Other Nu	rsing Home 5	Residence 6	Other:		
Division of Vital Records, rate of Attending Physician: The law require and order Attending Physician: The law require and prince of the this certificate has been sitted in by the funeral director, page 2 should be	L:	27. Manner of Death 1 Natural 5 Paneline May 21, 2010	y ar)	28b. Time of 1936 hrs	· · · _ ·	ury at Work?	28d. Describe Subject drov	how injury occurre wned	d		
Sior Attence r death ector: by the	cati	2 Accident Investigation			et, factory, office	Yes 2 ✓ No			and Donal Donal Months City		
Divi	Certification:	3 Suicide 6 Could not be determined Scify) Cre-		me, rarm, stre	et, ractory, office	building, etc.	or Town, S		r or Rural Route Number, City don. MD		
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my	knowledg				and due to the caus	se(s) and manner	as stated.		
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated.	nination ar	nd/or investiga	tion, in my opinio	n, death occurre	ed at the time, date	and place, and du	ue to the cause(s)		
	Ź	29b. Signature and title of bertiffer				se number			d (Month, Day, Year)		
3V				00.	0.0	.M.E. 		May 22, 201	IU 		
OCME		 Name and address of person who completed cause of de Mary G. Ripple MD. Deputy Chief Medic 			1 Penn Stree	t, Baltimore	, MD 21201				
S	tate	31. Date filed (Month, Day, Year) 32. Figistrar			217.303		· · · · · · · · · · · · · · · · · · ·	-			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 Physician/ W19 Fall 122 Clarence Mar AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death University of MANYLAND MEDICAL CENTER Baltmore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Director Usual Residence of Decedent "I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene." I health and Mental Hygiene. To sharked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ould be filed within 72 hours after death with the Maryland d Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ma 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) KOSA 2,2/2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot once. ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) ♠☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Lice 2122 23a. Part r. Enter the disease, or complications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest shock, or hear ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death.) Onset and Death h sician/ Pneumonia Medical Due to (or as a consequence of) Examiner Obstructive Polmenary DISECUSE Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Exami Cause (Disease or iinjury burial-trans within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Hospital or Attending Physician: The law requires that the death Pregnant at time of death 5 Other (specify) Month Day Year 4 ∐ Pregnam g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 22054 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RYAN 22 South Greene SWELT Baltimore, MD 21201 ARNULD

State Registrar

ate 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Y 25 2010 Januar & Jan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WALKER HENRIETTA 1:05 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death GOOD SAMARITAN NURSING CTR Social Security Number 29.48.2114 7. Age (In urs. last birthday) 8, Date of Birth Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Director Usual Residence of Decedent 28a-f show 10a. State 10b. County City, Town or Location 10d. Inside City Limits Funeral Director must be notified 1 Res 2 No 5 10g. Citizen of What Country? E. Federal Stree 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten Examiner r Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural" Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working tife. DO NOT use retired) al Hygiene. day (0-12) College (1-4 or 5+) of Health and Mental Hygie fitem 27 is marked other r other traumatic event, th Be ည Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition of Disposition Department of Important: If it any injury or o Surial 2 Cremation 3 Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv ce Licepsee 23a. Part 1. Enter the dis r complications that caused the death. Do not enter the mode of dyind, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death FAILURE HEART hysician/ CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULMONAM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 🖪 No 2 1 N Yes 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Director; / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 006 1789 29d. Date signed (Month, Day, Year) HWWOL, M MAY

Registrar
DHMH 17 Rev 7/2009

State

LORLAINE OFORI-AWUAH, MD, 5430 CAMPBELL BLVD, STE 214 BALTIMORE MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 23, 2010 4:00 PM Joan Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice Care Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Sept. 8 9. Birthplace (State or Foreign **Funeral** Year) 1938 Months Days Min. 72 Mary land Director 212-36-4282 Usual Residence of Decedent 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 3821 Blenheim Road 21131 USA iral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married 1 Yes 2 🛛 No and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 □ Divorced White "natural", Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene.
7 is marked other than traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Clothing 12 N/A Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thelma Dorr Department of Health and Men Important: If item 27 is marke any injury or other traumatic William Artka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Lynn Munsell/Daughter 1405 Clark Ave. Lutherville, MD 21093 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 X Cremation 3 Removal from State May 25,2010 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Emeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 J. Flagle 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ olon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Jause (Disease Ol imjury that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Day signed by the a 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 □ Nursing Home 5 □ Residence 6 🖾 Other (Specify) Wospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\subseteq \text{Homicide} \) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Division of Vital

> State Registrar

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANGS

 $_{o}$ $\langle N \rangle$ 82. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Chanle

TONSON MIT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 19 2010 John Winters, Jr. 6:55 PM D. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4th Avenue **Baltimore** Lansdowne 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🗆 F (Month, Day, Year) 08/06/194 Hours Country) **Director** 215-40-7687 67 MD Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 4th Avenue 21227 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No 1 ☐ Yes : 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Erection Specialist Construction I and 2 should be filed w I Health and Mental Hyg Item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John D. Winters, Sr. Orlena Neall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Charlotte Winters / wife 110 4th Avenue, Department of Health Important: If item 27 any injury or other tr Lansdowne, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). and -transit that the death certificate be executed Due to (or as a consequence of): burialphysician Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) jo in the past 12 months? Month Year Day Pregnant at time of death ed by the detached g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 2 No 2 No within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1- Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation Suicide Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier completed cause of death em 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Mar	ryland / L	•	ent of He ate of D		Mental Hy	giene Reg. No.	2010	163	305
	Physicia		1. Decedent's Name (First, Middle, Las Charlotte	t) Schuman		Wi	11i		2. Date of De Month May			3. Time of D	
	Medic Examin		4a. Facility Name (if not institution, give	street and number)				ocation of Death			County of Death	7.51	<u> </u>
			1406 Rowe Drive 5. Social Security Number 6. Se		f	1611	Glen Bi		T	Anne Arundel			
	Funeral Director		218-26-7730 1	M 2 F 7. Age (In yrs. last birti 79	Yrs. Mon		Hours Min.	8. Date of Bir Month, Da June 2	Birth 9. Birthplace (State or Foreign Nary Tand			
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location			-		1	0d. Inside City	Limits
	Mary 28a-f	Funeral Director	Maryland Anne Aru	ındel	Glen Bu							1 🗌 Yes 2	X No
	ith the 23a or st be r	ral					Zip Code			-	izen of What Cour	ntry?	
	tems	Fune	1406 Rowe Drive 11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was D	1061 ecedent of His	panic Origin? (Sp	ecify Yes or No-		S.A. 14. Race - Americ		
036	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "matural" are must be notified at matic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	0		es 2 💢 No	, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Spec <i>ify:</i> Whit		
S C	2 hour "natur	plete	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's	Usual Occupat	tion uring most of work	rina	16b. Ki	nd of Business In	dustry	
Maryland 21215-0036	ithin 7; ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO NOT prist	use retired)		9	F1ov	vers		
מ	filed wall Hygi dother vent, i	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden S	Surname)		
Зa	uld be Menta narked natic e	입	George R. Schu					Sadie E					
ā ⊠	shc ar		19a. Informant's Name/Relationship (Ty Mr. Steve Willi/	, . ,	19b. 985	•	lress (Street ar. 6th St.				Town, State, Zip (3051	Code)	
e,	1 and 2 soft Health of Health fitem 27		20a. Method of Disposition		20b. Place of	Disposition		May	gton, OI Date 22		cation - City or To	wn, State	
Baltimore,	Page tment tant: It		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Atlant:	ic Cre	matory	2010			Burnie		
Ball	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.	j j	21. Signature of Funeral Service Licens	fild M	01594				_		eral &Cre Burnie N		L
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused the cause on each line.	ne death. Do n	ot enter the	mode of dying,	such as cardiac	or respiratory ar	rest,		Approximate Interval Betwe	en
+	пузісіап/ Medical	9 1	Immediate Cause (Final disease or condition resulting in death)	a ACUTE		OCA	KDI	ALI	NFA	no	TION	Onset and Dea	ath
	Examiner	L	Sequentially list conditions,	Due to (or as a c	TE T	<u> </u>	HOL	SSTE	RO			25 YEA	ars
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a c	onsequence of	if):	MEL	Lite	c T	YF	25 2	2545	ARS
	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a c		,		- 10		/		25310	
/60	cate be physic s the bu	ledical	•	d. <u>17912</u>	RTZ	NSC	00				•	25 78	A2>
α ×	h certifi tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2		3 🗆 Ecto	pic pregnancy			2	23d. Date of delive	_	
. Box	he deatl y the att ched fo	Physician/M	1 Yes 2 No	4 Pregnant at ti 9 Unknown	me of death	5 🗌 Othe	r (specify)				Month	Day Yea	ar
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spic	require been si should	leted	PECIZEMOT	> 1212 M	1012				1 L		No 3 ☐ Prot	pably 4 Un	_
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00	eath. or: Afte the fun	Certificate:	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		<i>'ear)</i> ir	njury M	work?	es 2 🗆 No	_				
DIVISION	al or Att s after d I Direct d in by	Cert	4 Homicide determined	28e. Place of Injury building, etc. (9	 At home, far Specify) 	m, street, fac	ctory, office		28f. Location (S City or Tow		Number or Rural	Route Number,	105
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 44 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Examin	ician: To the best of my ner: On the basis of exar	mination and/or	investigation	, in my opinion	, death occurred a	t the time, date a	nd place,	and due to the cal	ise(s) and manne	er stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the be	st of my knowle	edge, death d	29c. License r	number			e signed (Month, L	Dav. Year)	
	,		Mucha	(21	1	10	DO	<u> </u>	5 19	MA	Y 24	, 201	O
1	30 V		30. Name and address of person who c	FISHER	> (VDE, Print)	IN To	DWE R	5,6L	EN	Burn	, 201 11E, M	1
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	0			,			,	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31 per DVR g903 5/25/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Marguerite Iris Wimmer P_{\bullet}^{M} 9:25 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 110 Fairmont Drive Bel Air 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Hours Min. Country) Director 95 213-01-9924 1914 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 110 Fairmont Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ pe John Harry Stanley Bertha Dove Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh iment of Health a tant; If item 27 is jury or other trau <u> Ellen Pfau / Daughter</u> Fairmont Dr., Bel Air. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) <u>Fallston U.M. Chr. Cem.</u> 5-29-101 Fallston, Maryland . Signature of Furteral Service Licensee 22 Name and Address of Facility
McComas Funeral Home, .A.. 50 W. Broadway. Bel Air Maryland 21014 Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician espiva tury disease or condition Medical resulting in death) 20 4RS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the how Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29b. Signati 2010 DO023519 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2303 Belain Rd. Fallston, MD 21047 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

tephen Michae		Please Type or I ight State of I- For State		Depar	tment	of Health ar of Death				201	0 630
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			meate (or Douter		2. Date of	Reg. No. Death		3. Time of Death
Medical Exami		Stephen Michael W	ight.					Month May 20	Day 0, 2010	Year	1954 hrs
		4a. Facility Name (if not institution, give str	eet and number)			4b. City, Town, o	r Location of C	Death		County of Death	1
		Upper Chesapeake Medical (Belair	_			larford	
Funeral		Social Security Number 6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1 Yes	_	4Hrs. 8. Date o	of Birth (MM/I	DD/YYYY) 9. Bir Foreig	an
Director		214-82-8576 ¹ XM	2F	50	Υ	rs.	, o Hours	Aug	. 26,	1959 ^c	untry) Maryland
À	- [Usual Residence of Decedent 10a, State 10b, County		10c City T	own or Loc	ation					10d. Inside City Limits
ow any					rchvi						1 Yes 2 X No
Aaryland 28a-f show Lat once.	흲	Maryland Harford 10e. Street and Number		Cit	LCIIVI	10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	Director	3413 McCommons Ro	oad			21028	₹		US	SA	
with the s 23a			. Was Decedent I	Ever in U.S	i. 13. V	Vas Decedent of H		? (Specify Yes o			ican Indian, Black,
leath r	Funeral	1 Never Married 2 Married 1	Armed Forces?	X No	1	Yes, specify Cuba	n, Mexican, P	uerto Rican, etc.))	White, etc.	
after o	by F	3 Widowed 4 Divorced If Y	es, Give Year Dates:	A_1 110	1[Yes 2 X N	o specify:			Specify: Whi	te
ours :	룺	15. Decedent's Education (Specify only h	ighest grade com			ent's Usual Occupa most of working life			16b. k	(ind of Business/	Industry
16 n 72 h uan "1 ical E	흥	Elementary/Secondary (0-12)	College (1-4 or 5								i
withi withi giene.	Completed	17. Father's Name (First, Middle, Last)	4		CPA-C	ertified		EXAMINE		Accounti	ng
115- e filed al Hys	BeC	William Patrick W	right Sr					or Cathe		, , , , , , , , , , , , , , , , , , ,	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	0	19a. Informant's Name/Relationship (Type	_		19b. Mail	ing Address (Stre					e, Zip Code)
MD d 2 sho lth and n 27 is		Krista Wright / W	fe		3413	McCommor	is Road	, Church	hville	e, Maryl	and 21028
e, le land land Healt	- 1	20a. Method of Disposition				osition (Name of co	emetery,	Date	20c. l	Location - City or	Town, State
TOF		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from Sta	re	•	Memorial	Gdn. 5	/26/2010	0 E	Bel Air,	Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite	- 1	21. Signature of Funeral Service Licensee				. Name and Addres				eral Hom	
E.E.S.	- 1	Kathleenan	antiva	sci	1	317 Cokes	sbury R	oad, Ab	ingdor	ı, Maryl	and 21009
Physician		23a. Part I. Enter the disease, or complicat failure. List only one cause on each I		the death. I	Do not ente	r the mode of dying	, such as card	liac or respirator	y arrest, sho	ock, or heart	Approximate Interval Between Onset and
/M oi J xaminer	- 1	Immediate Cause (Final disease a				ardiovas	cular d	lisease			Death
		or condition resulting in death)	to (or as a conse	quence of)	1						
	힐	Sequentially list conditions, if any, leading to immediate Due	to (or as a conse	quence of)	:						
_	Ë	(Disease or injury that initiated c.									
D a its	Examiner	events resulting in death) Last d.	to (or as a conse	equence or)	:						
executed ian and ial - transit	ical		MENDED	27	\(T	-005 7/2	/10 mm				
60, ate be hysici e buri	Ned		3c. If yes, outcom	2/,pe	r ME ancy	g905 7/2,	/10 11		230	d. Date of deliver	<u> </u>
587 artifica ling p	sician/Med	23b. Was decedent pregnant in the past 12 months?	Live birth		2 🗌	Fetal death 3	Ectopic p	regnancy		Month	Day Year
OX (sath ce sath ce sattence or use	Sici	1 Yes 2 No 9 Unknown	Pregnant at	time of dea	th 5	Other (Specify)			- [
the de	Phy	Part II. Other significant conditions con		but not re	sulting in th	e underlying cause	given in Part	l. 23e. E	Did tobacco	use contribute to	the cause of death?
P.C ss that gned l e deta	2	Diabetes, Hypert	ension.	hvner	chole	sterolem:	ia	1	Yes 2 ₩	No 3 Pro	bably 4 Unknown
ds, equire een si ould b	ompleted	_Diabetedy 11, peru	ing roll y	<u>, por</u>	011010	<u>Door Orom</u>			Was an		utopsy findings available
COF law r has b	ם							— I_F	autopsy performed?	death?	completion of cause of
Re : The ificate r, pag	S	25. Was case referred to medical				26 Play	o of Dooth (C	heck only one)	res 2 N	0 1 🗸 Y	es 2 No
rital sician is cert	Be	examiner? Hosp	ital: 1 Inpatie	nt 2 🗸 I	ER/Outpatie		(Other)	lursing Home 5	Reside	ence 6 Othe	er.
B Phy Rer th	5	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry T	28b. Time		ury at Work?			ury occurred	
Per alt.	ē	1 X Natural 5 Pending	(Month, Day, Yo	ear)		1	Yes 2 N	0			
r Att	fica	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inj	jury - At ho	me, farm, si	reet, factory, office	building, etc.			and Number or Ru	ural Route Number, City
Divoltal of the stand of the st	Certification:	4 Homicide determined	(Specify)					orlov	wn, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours at er ceath. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier (Check only 1 Certifying Physician:									
Somple Athin the	Medical		the basis of exar Dmanner stated.	nination an	d/or investi			rred at the time,			
	Σ	29b Signature and title of certifier	,6)/	1//	MON		nse number			Date signed (Mo	onth, Day, Year)
		Occilo State	Wel	d-		0.0	.M.E.		Мау	y 21, 2010 	
\mathbb{V}		30. Name and address of person who com- Victor Weedn MD JD Assi	pleted cause of d stant Medical			Penn Street,	Raltimore	MD 21201			
- F		31. Date filed (Month, Day, Year)	32. Registra				Daitinore,				
	tate	(.mornin, Day, rour)	1								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY R. WALLICK MATY 24, 2040 8:00a. Medical 4a. Facility Name (if not institution, give street and number)
3319 TRELLIS LANE 4b. City, Town, or Location of Death Examiner 4c. County of Death
HARFORD ABINGDON Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Hours 977777996 ÑEŴ^{Y)}YORK Director 362-12-6442 Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD HARFORD ABINGDON 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 3319 TRELLIS LAND 21009 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 ģ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify WHITE If Yes, Give 3 X Widowed 4 □ Divorced "natural", Specify Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Flementary/Seconday (0-12) College (1-4 or 5+) WAITRESS RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN SCHWARTZ JULIANNA SLAMIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN WALLICK, JR/GRANDSON 3319 TRELLIS LANE ABINGDON, MD 21009 permit. Page 1 and 2 Department of Health Important; If item 2 any injury or other 1 once. or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 5/28/2010 BALTIMORE, MD Signature of Funeral Service Livenses 22. Name and Address of Facility M01139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ASC -D disease or condition resulting in death) Year Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a considuence of cause. Enter Underlying Exami Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Anemia 1 Tes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas , page 2 performed? Yes 2 No After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 ☐ Yes Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 🗷 Natural 5 Pending Accident 2 🗌 No Investigation within 24 hours after deat To the Funeral Director. completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, WIC 5/24/13 D 31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo K10-052 Back, MD 2125% 570 Kenwind 2010 Regist 31. Date filed (Month, Day s Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g903 5-25-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 5 2<u>010</u> Month MAY Physician/ \mathbf{A}^M 7:45 WEBER PATRICIA Η, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE **ESSEX** 544 HOPKINS LANDING DR 8. Date of Birth (Month, Day, Ye NOV . 20, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign) . Age (In yrs. last birthday, Social Security Number **Funeral** Min. NEW JERSEY Months 1 □ M 2**X**XF Hours Yrs. 192188 126-20-3886 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State with the Maryland Director an "natural", or items 23a or 28a-f s' Medical Examiner must be notified 1 Yes 2 XNo BALTIMORE MIDDLE RIVER MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21220 705 COMPASS ROAD, APT. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3XXWidowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) YEARS Elementary/Seconday (0-12) traumatic event, the PLUMBING BOOKKEEPER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ MOODY BURGESS AUGUSTA **THADDEUS** MARY permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2406 LINDA LANE JARRETTSVILLE, MD 21084 RUTH O'CONNELL/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATION SER. 5/17/2010 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MILLER-DIPPEL FUNERAL HOME, INC.
6415 BELAIR ROAD BALTIMORE, MD Approximate Interval Between Onset and Death is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure Immediate Cause (Final disease or condition Inon Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached 9 Unknown Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1: X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No 2 No 1 🔲 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Hospital: daughter Other: 2. No 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 To Re 1 Yes ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hours To the Fune completed file 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Dms. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G904, 6/8/2010, WS

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day athryn 2) " de per M Medical 4a. Facility Name (if not institution, give street and nun 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balhina N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Min 304-36-3502 Country) Indiana Director 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 🗆 Yes 2 🖾 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 251 Lower Magothy Beach Road 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Property Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell Franklin Ward Wilma Kathryn Nagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 Allan Young (Wife) (Husband) 251 Lower Magothy Beach Rd Severna Park. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge MEmorial Park 5/22/10 4 Donation 5 Other (Specify) Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman 7250 Washington 21. Signature of Funeral Service Licenses Funeral Home at MMP 21075. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on ised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death -Chysician/ disease or condition resulting in death) Introcreme Medical Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner 11 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Hospital or Attending Physician: The law requires that the death Pregnant at time of death 5 Other (specify) Month Day Year Yes 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 器 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 13:30 1 Yes 2 No hours after death uneral Director: / 01 110 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location Street and Number or Rural Rout Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To he best of my knowledge, death occured at the time, date and place, and due to the cause(s) and mariner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 1619138013 who completed cause of death tem 23a) (Type, Print) 30. Name and ago 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day ESTHER ASHTON MAY 2010 1903 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 1 F 577-42-2613 79 2/13/1931 Washington, DC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Ridge Road 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 € Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Mental Health Counselor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Ashton Bertha Griffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jervette M. Ashton/ Daughter 911 Comanche Dr. Oxon Hill, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) Fort Lincoln 5/11/2010 | Brentwood, Maryland 21. Signature A Foneral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arr st, shock, or heart failure. List only one cause on each line.

Immediate Cause Final disease or conditions. Approximate Interval Between Onset and Death COMPLICATION OF NECK INJURY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPTIC SHOCK . CONGESTIVE HEART FAILURE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION, DIABETES MELLITUS autopsy performe PNEUMOHEMIA, MORBIT OBESITY 1 □ Yes 2 □No 2 X No 26. Place of Death (Check only one) 1∏XYes 2☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Syncopal Bed Episode fell out of at Home 28c. Injury at 1 🗀 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 X Accident Unknown Unknown

Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, e Hospital or Attendi ≥4 hours after death. e Funeral Director: A letely filled in by the fu

Physician

Examiner

Funeral

Director

28a-f show

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Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. and I fitem 27 is marked other than "natural", or iten any or other traumaft event, Its Marical Exeminary or other traumaft event, Its Marical Exeminary.

Department o Important: If any injury or once.

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Examiner

Physician/Medical

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Baltimore, Maryland 21215-0036

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Completed

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death with the Maryland

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within 2. State Registrar

Be Completed 25. Was case referred to medical examiner? Certification: To 27. Manner of Death 6 Could not be 3 ☐ Suicide determined 4 Homicide 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6500 Riggs Rd Hyattsville, MD 20783 Hyattsville, 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

ho completed of death (Item 23a) (Type, Print) 7600

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20912

2010

Date filed (Month, Day, Year) 1 2 2010

30. Name and address of person

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.												
Physicia	an/	Decedent's Name (First, Middle)		-				2	. Date of De Month		Year	3. Time of Death		
Medical Exami	ner		san Buell							May 8, 2	010		1329 hrs	
)		4a. Facility Name (if not institution 2119 Bethel Road	n, give street and nu	ımber)		41	b. City, Town, or Finksburg	r Location	of Death		4c. Cou	nty of Deat	h	
Funeral Director		5. Social Security Number 218–74–4283	6. Sex 1 M 2 F	7. Age (In y	s. last birt	hday) Yrs.	If Under 1 Year Months Day				irth(MM/DD/Y) 4, 1959	Forei	orthplace (State or Maryland ountry)	
MD 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene. m 27 is marked other than "natural", or items 23s or 28s-f show any aumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Carroll 10e. Street and Number 2129 Bethel Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) James Marion Buell 19a. Informant's Name/Relationship (Type, Print) James M. Buell, brother					Decedent of His, s, specify Cubar Yes 2 No Susual Occupa at of working life nk Tello	Finks 210 spanic Origin, Mexican o specify: tition (Give o. DO NOT er 18.Mother Li et and Nun Ave,	bburg 148 gin? (Spector, Puerto Rich, Puer	cify Yes or Nican, etc.) rk done rirst, Middle, 1 M . G. ral Route Nu	10d. Inside City Limits 1			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify: Licensee		Churc	22. Na 91	God Cer me and Address Willis	s of Facility Stre	et, W	ers-Du Vestmi	rboraw nster,		cal Home 1157	
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)												
scuted and ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a c. Due to (or as a						<u>.</u>					
P.O. Box 68760, so that the death certificate be excepted by the attending physician.	by Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk Part II. Other significant condition	e 1 Live b 4 Pregn nown 9 Unkno	irth ant at time of wn	death 5	Fetal Othe	death 3 [c pregnanc	23e. Did to	Month obacco use co s 2 ✓ No	ntribute to	the cause of death? bably 4 Unknown topsy findings available	
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of ong Ph	Certification: To	3 Suicide 6 Could	28a. Date (Month, May 8, 2 tigation and be	of Injury - Al	28b. T 1317 home, far		ıry 28c. İnjur	ry at Work	No Pe	d. Describe edestrian		urred uto	ral Route Number, City	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical Cer													
WIL 6		29b. Signature and title of certifier 30. Name and address of person Victor Weedn MD JD	alter	Selde of death (Ite		111 Pe	29c. License O.C.M	M.E.	e, MD 21	201	29d. Date si		nth, Day, Year)	
Sta	77.0	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign			4		-					
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d 2	filed v Hygie other		17. Father's Name (First, Middle, I	ast)		1100	nan ca	Engineer 18. Mother's Nam	e (First, Middle	, Maiden Surname)	ii ace
<u>a</u> n	ld be lental ked c	To Be	Thomas A.	Booth				Helen	1	ou lin	
Maryland 21215-0036	shou and N s mar	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Ma	iling Address (Str	eet and Number or Ru		per, City or Town, State	e, Zip Code)
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Evantine must be notified at once.		Shirley R.	Booth /WI	ife_	7 No	orth Par	Kway, E	- lKton	MD 21	921
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition	f 3 □ Removal from State		Place of Dis cemetery, cr	position (Name of ematory or other p	place)	Date	20c. Location - City	or Town, State
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	/Medical		disease or condition resulting in death)	a. Due to (or as		uence of):	ishmi	ntic			years
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Box 687	Hospital or Attending Physician: The law requires that the death certificate 1.24 hours after death. Funeral Director: After this certificate has been signed by the attending physitely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical		u							
ŏ	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			B ☐ Ectopic pregna	ancy		23d. Date of	,
	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a			Other (specify)			Month	Day Year
9.	hat thed the set by set act		9 ☐ Unknown Part II. Other significant condition	s contributing to death h	ut not resu	ulting in the	underlying cause	given in Part I	23a Did t	tobacco use contribute	to the cause of death?
Division of Vital Records, P.O.	uires that signed I d be det	d by		or-sula		يتطييا		given in raiti.		Yes 2 □ No 3 □	
S	w requir s been si shou!d l	Completed				1000			24a. Was		autopsy findings available
Be	sician; The law certificate has t rector, page 2 sl	dwo							autor	psy prior to prmed? death	to completion of cause of
<u>ta</u>	ian; J	Be C	25. Was case referred to medical					26. Place of Deat	1 □Yes h <i>(Check only c</i>	2 XNo 1 □Y	es 2□No
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Sio	ttendi feath. tor: A	cati	2 Accident investiga 3 Suicide 6 Could no	t ho				□Yes 2□No			
Ξ	or Al after d Direct in by	ərtifi	4 Homicide determin	ed 28e. Place of Inju- building, etc	ury - At ho c. <i>(Specif</i>)	me, farm, s	treet, factory, offic	e	28f. Location (: City or To	Street and Number or wn, State)	Rural Route Number,
	spital		29a. Certifier 1 Certifying	Physician: To the best of	of my know	wledge, dea	ath occurred at the	e time, date and place	and due to the	cause(s) and manner	as stated
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	f examinat	tion and/or	investigation, in m	y opinion, death occur	red at the time,	date and place, and d	ue to the cause(s)
	To the Ivithin 24	Me	29b. Signature and title of certifier	2			29c. Lice	ense number		29d. Date signed (Mo	nth, Day, Year)
			brunde i	<u>_</u>			Do	ce f 73 c		05/10/10	
	_		30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type	Print)	MGH ST	no ot	FILEND	MA 2192 1
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	Sta Registra	~	WAY 1	2 2010 Zens	wa.	4	barked				

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Amend item:8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month Monique 10 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hos Year 9. Birthplace Gountry) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Vear) Hours Months Days 1□M 2**X**F 215-61-0114 Usual Residence of Decedent 61-0114 25 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Manyland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕻 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) P.G. Count 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denn Father MD Marcelles 11315 6 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 20608 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on thine. Approximate Interval Between Onset and Death Do not enter the mode of dving Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pl pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2□No 1□ 25. Was case referred to medical examiner?
1 Des 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r

I Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event.

Funeral Director

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Completed

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death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and burial-trar physician

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After t

24 hours after death e Funeral Director:

Physician;

or Attending

Hospital

þ signed to

Examiner Physician/Medical þ Completed Be Certification: To

Ho	spital:	1 patient	2 🗀	ER/Outpatient	3 🗆 🛭	OOA Other:	4 ☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)	
		Date of Injury (Month, Day Ye	ear)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred	
	28e.	Place of injury - building, etc. (S	At ho Specif	ome, farm, stree	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one)	1
---------------------------------------	---

27. Manner of Death

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

b. Signa	ature and	title o	rectifier	A	N			100)
Name	and addr	ess of	person w	vho comple	ted caus	e of deatl	(Item 23a	(Type, Pri	nt)

5 ☐ Pending investigation

6 Could not be

Livingston Rd, Ft.

29d. Date sign ed (Month, Pay, Year)

B	31	0	
g.		Sta	te

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY Day Year OLIVE MAE BUTLER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 🗆 M 2 🗷 F 216-60-0910 56 NORTH CARCLIN Director Usual Residence of Decedent Show 10a. State 10b. County be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director FREDERICK 28a-f MYERSVILLE MD. 1 Yes 2 No ъ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? MOUNTAIN TERR, RD. 23a 21773 USA must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry المالية filed with. ما Hygiene. مد than "r (Specify only highest grade completed) FRED ERICK COUNTY Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL BOARD TIT JANITORIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked of ျှ JOHN CALVIN WOODLEY MAUDIE STALLINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 'MD SON) 238 MOUNTAIN TERR. RD. MY ERSVILLE 120 DAVID BUTLER or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, MAY 11, 2010 FREDDERICK MD. 4 Donation 5 Other (Specify) FAIRVIOW COM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROCURS FUN, HOME Rollin rang X. FREDERICK MO 110 WEST SOUTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Pregnant at time of death 9 Unknown the detached P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No ieral Director: After this certificate filled in by the funeral director, pag Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No Accident Suicide Investigation Could not be 24 hours after deat Funeral Director: 6 🗌 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) etermined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of cg 29d. Date signed (Month, Day, Year) 00 MDD 62471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W 7th St Abbas 21701 WD Frederick

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)
Ralph Joseph Bozzo Month 05/10 2010 ear 01:13рм Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Burnett-Calvert Hospice House Birthplace (State or Foreign Country)
 NTT Date of Birth Month, Day Year) 03/26/1921 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days Hours **Funeral** 070-18-9648 1 → M 2 □ F 89 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examities must be notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Owings Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20736 6901 Ash Court Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 AYes 2 No
If Yes, Give 1 ☐ Never Married 2 A Married White 1 ☐Yes 2 TNo Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) N.Y City Transit Auth. College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Compitello Joseph Bozzo ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6901 Ash Court, Owings, MD 20736 Robert Bozzo/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Calverton, NY Calverton National Cem 05/14/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Sign ure of Funeral Service / ensee 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Mourts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Pancreatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician P.O. Box 68760, Physician/Medical the for use as 23d, Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No ned by the a 9 I Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed to Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed 2 □No 1 □Yes 1 □ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 No 1 ☐ Yes မ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day, Year) 27. Manner of Death After 1 Medical Certification: Hospital or Attending Natural 5 Pending 1 ☐Yes 2 ☐ No investigation death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e Funeral I 29a. Certifier

jew

To the l

State

(Check only one)

31 Date filed (Month, Day

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signatu

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 11, **Physician** Daisy Elizabeth Buckler 4:40 AM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 □ F Director 217-28-2093 86 May 30,1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 X No Marvland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Wildflower Lane 20639 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: δ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Florist Flower Shop 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important; If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Franklin Dodson ဂ Daisy Elizabeth Lusby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Buckler, Jr. / Son 2505 Wildflower Ln., Huntingtown, MD. 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 05/14/2010 Prince Frederick, MD. 22. Name and Address of Facility Rausch Funeral Home, P.A 8325 Mt. Harmony Lane, Owings, MD. 20736 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Carolio Vascula discar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) burial-Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy po in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Congestive Heart Failure, Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Obstanctive Airway clinease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Atrial Fibrillo Hion 2 **N**o 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Impatient 2 □ ER/Outpatient 3 □ DCA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1RW

24 hours a

within 2 To the I

completely

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and

attending physician

the

signed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

(Check only one)

5851

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jan . C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

urang-

churchfor

32. Registrar Signature

1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D. 50653

GYAN.C

Deale

29d. Date signed (Month, Day, Year)

5/11/20/0

SURAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year -00KS eba ache Mai 25 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 405 Pice a Talbot House 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕏 F 8 Months Days Hours Min. 0 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No aston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral USA house 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No þ Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supermarket 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Avaustus Helen brooks 19a. Informan Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooks 8816 Roundhouse Annette Easton, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/10 4 ☐ Donation 5 ☐ Other (Specify) 's Mem. Park 22. Name and A dress of Facility Easton, 21. Signature of Funeral Service Licensee 23a. Parts: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) MD,21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Luna Lancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □Yes 2 N/No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS 1 Yes 2 XNo 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 No

Examiner Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760. signed by the a has page 2 s certificate

Physician /Medical

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Midfal Examiner rust to account and another traumatic event, the "Midfal Examiner rust to account and another traumatic event, the "Midfal Examiner rust to account and account account and account and account and account and account and account and account and account and account and account and account and account and account and account account account and account account account and account account account and account account account account account and account acc

Baltimore, Maryland 21215-0036

Physician/Medical ģ Completed Be

Certification: To

Medical

director,

After this funeral

24 hours after deat Funeral Director: filled in by the

within 2 To the

State

Registrar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be determined

29c. License number

EASTON

29d. Date signed (Month, Day, Year) 2010

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAIDYANATHAN 219 5. WASHINGTON ST,

31. Date filed (Month, Day, Year) MAY 13 2010

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only

32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert L. Barker P^{M} Mav 6 3:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2383 Broad Run Court Jefferson Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Date of Bird. (Month, Day, Year 23, 9. Birthplace (State or Foreign Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours 1925 Ocala, 85 Director 220-12-3013 Florida January Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f Maryland Frederick 1 X Yes 2 No Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2383 Broad Run Court 21755 TISA items filed within 72 hours after death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian ò 1 Never Married 2 Married Black, White, etc. þ 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed WWIT Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **PEPCO** Transmission Coordinator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be William Rolfe Bettie Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a Annamary Barker / Wife 2383 Broad Run Court, Jefferson, MD 21755 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 a Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or injury or 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Fort Lincoln Cemetery 5/11/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Soy Gasch's Funeral Home, PA RAY Rogers Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pitysician/ Metastatic Melanoma disease or condition Medica! resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death Other (specify) Month Yes 2 No q 🗌 Unknown g Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 🔀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Kent Bonham,

31. Date filed (Month, Day, Year)

MAY 1 2 2010

D54451

22911 Jefferson Blvd., Smithsburg, MD 21783

5/11/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 LAVERN **BROOKS** ELIZABETH 12817P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. NOV . TI Year 946 Director MARYLAND 214-48-9046 Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director LANDOVER PRINCE GEORGE'S MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1213 NALLEY ROAD 20785 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 🕅 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9TH CUSTODIAN GOVERNMENT Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ BOONE THOMAS BARNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troope. 7426 BELLE HAVEN COURT HYATTSVILLE, MARYLAND 20785 BROOKS COOK/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 5/14/2010 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASTRODUODENAL disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** TONEAL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 🗓 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pendina 2 Accident 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of MDD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ecilD. Gora

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7500 Hanovertarkway

Suito 101A, Greenbelt, MD, 20176

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2010 Year Patsy Ann Brooks 8 2:25 Medical 4a. Facility Name (if not institution, give street and number) 'Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 - M 2 X F Hours Min. 9 - 29 - 48 577-66-1369 **Director** 61 Wash. DC Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George' 1X Yes 2 No Forestville 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8587 Ritchboro Rd. 20747 USA items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Completed 3 Divorced 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supply Analyst Fed. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilmer Connor Alice Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Anthony Brooks/ Spouse 8587 Ritchboro Rd. Forestville 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lincoln Memorial 5-14-10 4 Donation 5 Other (Specify) Suitland, MD 22. Name and Address of Facility Pridgen Funeral Service 21. Signature of Funeral Service Licen 9013 Annapolis Rd. Lanham MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dusum **€**Medical Due to (or all a consequence of). Examiner SARCUIDOSIS Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ► No Day Pregnant at time of death 1 Yes 2 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? death? 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☐ ♠o ၉ 1 Pinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 9. 2010 cerne of D32206

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(1701 Livington Rond Fort WASHINGTON

10-03571 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death akpma Park	4c. County of Deat	h					
Funeral Director			1/31/19/5	thplace (State or Foreign ountry) Salvador					
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
				1 X Yes 2 No					
5-0036 downtin 72 hours after death with the Maryland lyggene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Completed by Funeral Director	10e. Street and Number 531 Bond Street	f. Zip Code 07206	10g. Citizen of What Cou El Salvado	•					
or items 23	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever	cedent of Hispanic Origin? (Specify Y pecify Cuban, Mexican, Puerto Rican,		ican Indian, Black,					
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136 hin 72 hor e. than "na edical Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT use retired)							
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natura e event, the Medical Exami o Be Completed b	17. Father's Name (First, Middle, Last) Wareho		PetCo Middle, Maiden Sumame)	_					
	Santos Chicas	Maria Laur							
O & 5 in in in in	Javier Barraza (Husband) 531 Bo	Mress (Street and Number or Rural Ro nd St. Elizabeth,		, Zip Code)					
MOFE, Pages I ar bent of Heg tunt: If ite	T Donation of Other opecity.		6, 2010 El Sal						
Baltime permit. Pag Department Important: injury or of	21. Signature of Funeral Service Licensee 22. Name		n/Hale Funeral	Home					
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Macical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death					
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ox 68: ath certifi attending or use as 1	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (ath 3 Ectopic pregnancy	23d. Date of delivery Month D	ay Year					
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificati	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at Medical Examiner: On the basis of examination and/or investigation, in	the time, date and place, and due to the	he cause(s) and manner as state	d.					
Σ	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)					
2	CMS C	O.C.M.E.	May 9, 2010						
1-3		t, Baltimore, MD 21201							
State Registrar	31. Date filed (Month, Day Year) 32. Registrar's Signature								

7	Amend	It	em # 5,19a Pleas	e Type or Prir	nt in I	Black In	delible Inl	k. Enst	ıre A	II Copie	s Ar	e Legible) .	
•	CCII	-	Item # 5,19a Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Co. Health Dept. State of Maryland / Department of Health and Mental Hygiene Contificate of Death											
			Registrar Certificate of Death								Reg. No. 2			
	Physicia Medic			May Cook						Month May		20 10 Year		3. Time of Death 14:45 PM
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	yland f shor	ctor	10a. State 10b. County		10c. City	, Town or Loc	ation						10d	I. Inside City Limits
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	with th	eral I	106 Champlain Re	oad			10f. Zip Code 219	201			-	Ditizen of What C ited Sta		
	leath v	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S		as Decedent of Hi	spanic Origi	in? (Spe	cify Yes or No-	011	14. Race - Am	erican	Indian,
36	after o	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 X	No		Yes, specify Cuba ☐ Yes 2XXNo		Pueno	rican, etc.)		Black, Whi		ite
9-0	hours natura ical E	lete	15. Decedent's		- 1	16a. Deced	ent's Usual Occupa	ation	_		16b	Kind of Business		
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Markeal Examiner must be notified at	Completed by	(Specify only highest selementary/Seconday (0-12)	grade completed) College (1-4 or 5-	+)	(Give k life. DC	ind of work done d NOT use retired) omemaker	luring most (of workii	ng	100.	Own Hor		su y
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ryla	ould be fil nd Mental marked matic ev	-	Warner Lee Sl			T				che Shi				
	ge 1 and 2 should be nt of Health and Men If item 27 is marke or other traumatic		196 Informant'a Name/Relationship David J. Cook,	Sr. / Spous	e		g Address (Street a							de)
Baltimore,	of He of He or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Pl	lace of Dispos	sition (Name of atory or other place	e)		Date	20c.	Location - City o	r Towr	n, State
ţim	it. Pag rtment rtant: njury c	3	4 Donation 5 Other (909		на		atory or other place Memorial ns			Aberdeen, Maryland				
Ba	permit. Page 1 a Department of h Important: If ite any injury or ot	0. 3	21. Signature of the control of the	nsee			Name and Addres					ral Home East N		y1and21901
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-	Medical Examiner		resulting in death)	D to (or as a	consequ	ence of):								
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.89	certific anding use as	JW/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		ncy	F-1					23d. Date of de	elivery	
P.O. Box 68760	requires that the death certificate be reen signed by the attending physicis should be detached for use as the bur	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnance Other (specify)	у			Month Day Year			y Year
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:									and Number or Rural Route Number, ate)			
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 L Medical Exar	ysician: To the best of miner: On the basis of exa	amination	and/or investig	gation, in my opinion	n, death occi	urred at 1	the time, date a	nd place	e, and due to the	cause	(s) and manner stated.
	To the within To the compl		only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the b	est of my	knowleage, as	29c. License		ind place			(s) and manner as ate signed (Mont		
			In ee No	-MP			D04	823	,		5	16/10		
	2_		30. Name and address of person who	completed cause of dea	ath (Item :	23a) (Type, Pr	int)	- M.	Wi	A	C	11cha	U.	1)14)1
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	ire CL	5 min	. 40	4	80	2	1170	- ((419
	Registra		MAY 11	2019		A A	arked							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 Betty LaVerne Colbert 11:14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 7204 Milligan Rd. Prince Georges Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 31 Mary Land 1 ☐ M 2**X**XF Months Hours Director 215-26-9432 78 1931 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🗓 No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 20735 7204 Milligan Rd death v 12. Was Decedent Ever in U.S. Armed Forces?
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Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Resurrection Cemetery May 11, 2010 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. M01555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner anoneado Cant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Cardego anow tema Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
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1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe this certificate 1 Yes 2 No 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 🗌 Yes 2 **N**0 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After Matural injury 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital within 24 hours a To the Funeral D Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

6357 Oxon Hill Road, Oxon Hill, MD 20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month Physician/ Year 7:25 p M May Hubert Wilkins Coleman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LaPlata Charles Civista Medical Center 8. Date of Birth (Month, Day, Ye March I, Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 177-24-5404 78 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. 10c. City. Town or Location Director 1 🗆 Yes 2 🔀 No MD Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3775 Chicamuxen Road 20658 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Ejection Systems Specialist Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blair Albert Coleman Margaret Anzella Dodd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blair Coleman/Son permit. Page 1 and 2 Department of Healt Important: If item 2 P.O. Box 1150, Marbury,MD 20658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Bunal 2 ☐ Cremation 3 ☐ Removal from State injury or Maryland Veterans Cem. 5/19/2010 | Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Arehart-Echols Funeral Home, PA 21. Signature of Funeral Service Licensee M00945 any P.O. Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last nsequence of) attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Vear 4 ☐ Pregnant at time of death g ☐ Unknown Day should be detached 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? performed? Yes 2 \(\sum \) No this certificate 2 🗆 No 1 🗌 Yes completed filled in by the funeral director, of Vital Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending Natural Division within 24 hours after death.

To the Funeral Director: Al ☐ Accident Investigation Suicide Could not b 3 Suicide 4 Homicide 2 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nug tioner: To the b st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 30. Name and address of p use of death (Item 23a) (Type Print) .DC Yazdani 31. Date filed (Month, Da State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Month Physician/ 24 APRII CLITES LYNN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany Rt. 36 Westernport If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day Yea Aug 30, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F Months GA Director 179-54-5985 49 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Frederick Middletown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 7203 Beachtree Drive USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walter Robinette Donna (Harris) Dentinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7203 Beachtree Drive Middletown MI MD 21769 Timothy Clites husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Semation 3 Removal from State 4/28/201b MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servis 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) bunial-Completed by Physician/Medical requires that the death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Ambulance 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after deural Director: Aftr 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after de To the Funeral Directo ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart	tment of Health and M ficate of Death		2010	16328					
		_	Registrar 1. Decedent's Name (First, Middle, Last)	ilcate of Death	2. Date of Dea	Reg. No: U	10000					
	Physicia Medic		VIRGINIA NAYLOR DAVIS		Month MAY	10 2010	3. Time of Death 1:40p M					
	Examin		4a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of Death		4c. County of Deat						
. '	<i>)</i> 		Autumn Assisted Living	Hagerstown		Washin	gton					
	Funeral		1 M 2 VIF	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min,	8. Date of Birth (Month, Day	9. Bir Year) 9. 3 Ma 1913 Ma	hplace (State or Foreign Intry)					
	Director		215-20-2363		Sept 2	1913 Ma	ryland_					
	and show	ō	10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits					
	faryk 8a-f tified	ect.	MD Harford Bel Air				1 🗌 Yes 2 🙀 No					
	or 2	ă	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?					
	with s 23a ust b	Funeral Director	109 Hibiscus Court	21014		U.S.A.						
	death item	교	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Ame						
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	l by	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No Specify:		Black, White Specify:	White					
Ş	ours :	Completed	3 □ Widowed 4 🔀 Divorced Year or Dates.	t's Usual Occupation	Т							
15	72 h In "na Medio	ď	(Specify only highest grade completed) (Give kind	t's Osual Occupation d of work done during most of workii IOT use retired)	ng	16b. Kind of Business	Industry					
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þ	be filed vental Hygred Ked othe		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, I							
/lar	should be file h and Mental 7 is marked c traumatic eve	욘	John William Naylor	Helena	Woodal	11						
an	should and li is ma			Address (Street and Number or Rura	l Route Number,	City or Town, State, Zip	Code)					
Σ	and 2 s Health tem 27		Carolyn Martin (daughter) 10	9 Hibicus Ct.	Bel Ai	ir, MD. 2	1014					
ore	of He		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cremative		Date	20c. Location - City or	Town, State					
<u>Ĕ</u>	Page 1 ment of tant: If it jury or o		4 Dopation 5 Dother (Specify) Galena C	Cemetery 5/1	5/10	Galena,	MD.					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signalure Funeral Servic Librasee M00510 Gall	ame and Address of Facility Lena Funeral H B West Cross S	ome of	Stephen	L. Schaech					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
, Ann	Physician/			Z Cendro Vico	rau D		Interval Between Onset and Death					
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	and and I-tran	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
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89	certii andine use a	N/	IF FEMALE: 23b. Was decedent pregnant in the port 10 menths? 23c. If yes, outcome of pregnancy 1	ctopic pregnancy		23d. Date of del	ivery					
P.O. Box 687	death	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 O	otopic pregnancy other (specify)		Month	Day Year					
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σ.	es tha igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the under	enying cause given in Part I.		bacco use contribute to	obably 4 Winknown					
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Division of Vital Records,	law r has b e 2 sl	Completed	A CONTRACTOR OF THE PARTY OF TH	auc	24a. Was a autops perfor	sy prior to d	opsy findings available completion of cause of					
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ita	sician certif recto	Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpution: 2 FR/Outputient	26. Place of Death (Check		AUTI	MY ASSISTED					
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ů.	nding tth. : Afte e fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	od. Doddingo iid	W many occurred						
isio	Atter	Certificate:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street,	factory, office		reet and Number or Rui	al Route Number,					
<u>≤</u> .	ital or ars after ral Dir lled in	al C	building, etc. (Specify)		City or Towr							
	Hosp 4 hou Funer ted fill	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigal	tion, in my opinion, death occurred at	the time, date an	d place, and due to the	ause(s) and manner stated.					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deal 29b. Signature and title of certifier	th occurred at the time, date and place 29c. License number	e, and due to the	cause(s) and manner as	stated.					
	F > F &		-att mo	D0018010								
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print	1-		nay 10,	2010					
	1			TAGEPSTOWN 1	nb 217	40						
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Registra	ir	MAY 1 2 2018 June B. pa	Mad								

DHMH 17 Rev 7/2009

J.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Flora Detrick 2155 Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nusring Home Frostburg Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) ost <u>Virginia</u> Days 1 - M 2 X F Hours **Director** 215-18-8651 89 05/04/192 West Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1508 A Oldtowne Manor 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ₩ Widowed 4 Divorced Specify Year or Dates. WWII White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) life, DO NOT use retired) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Arnold Parker Moreland Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Detrick /Son 12 Vocke Road, LaVale, Maryland item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Sunset Memorial Park 05/11/2010 Cumberland, MD f Funeral Se 21. Si mar. 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORDNARY Ph sician/ DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any leading to immediate Examine Due to (unas a consequence of): If any leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year 12. Programs after death.
2. Funeral Director: After this certificate has been signed by the a stand filled in by the funeral director, page 2 should be detached for the funeral director. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 **N**O Other: မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Thichen D26907 May 10, 2010 1-VA

Registrar

32. Registrar's Signature

925 Bishop Walsh Road, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit S. Sidhu, M.D.,

11 2010

31. Date filed (Month, Day, Year

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OMa Medical 010 "ZOAM Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jalis wicomico at-If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 1 M 2 □ F 05 Director Mary Usual Residence of Decedent items 23a or 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event; the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 16/3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No þ 1 Never Married 2 Married Black, White, etc. 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ InKnown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) armen ine ambridge 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Bethe 4 ☐ Donation 5 ☐ Other (Specify) CeMetery 15/10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uneral Home, P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a ARTHEROSCLERO TIC CARDIO VASCILAR DISFIAS disease or condition Medical resulting in death) Examiner BILATERAL GANGRAHOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician dbe detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 1 Tyes been s 24b. Were autopsy findings available 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 prior to completion of cause of death? 2 400 Yes 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one Gertifying Norse Prantioner: To the best of my knowledge 29b. Signature and title of certifier DO05 7410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Humry 130 X 1730 WARY 21802 SALISBURY 31. Date filed (Month, Day, Year) State MAY 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Entzian Teresa 8 2010 Mav 10:18 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 7846 Americana Cir. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days July 25 1 M 2 X F Hours ^{Year]} 19<u>59</u> Director 220-70-5332 50 Yrs Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21060 7846 Americana Circle, T-2 USA death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Cashier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F 2 Louise Kelly Joseph B. Pearson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 7846 Americana Circle, T-2, Glen Burnie, MD 21060 Constantine Coloccia, companion other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, injury or 1 Burial 2 Cremation 3 Removal from State 14 2010 4 □ Donation 5 🗷 Other Brottombment Evergreen Memorial Grid Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home any 91 Willis Street, Westminster, MD 21157 83a. Part.). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Nonknown Completed phode 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? certificate Yes 2 XN 1 Yes 2 No Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending

Records, Vita Division of

within 24 hours after de To the Funeral Director completed filled in by the the 2 WIL 2

24 hours after death. Funeral Director: A

Accident

Suicide

4 Homicide

29a, Certifier

(Check

only one)

31. Date filed (Month

29b. Signature and title of certification

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Red

6 Could not be

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

300

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

2010

061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Little Ebert 2010 2200 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ₹ M 2 □ F 93 Director 304-18-7849 06/16/1916 Virginia West Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 826 Mt. Royal Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) President Retail Store 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Gale Ebert Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Hardinger / Daughter 114 Midhurst Road, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or conce. 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 05/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Licenses Ud 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. erval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 10 Romany Mm Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the bunal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death detached 9 Unknown 9 Unknown þ Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Tibron's 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2/ No 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

INA noh State

To the within 2

29a. Certifier

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jesus H. Tan, M.D.,

1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D21244

Frostburg, MD

29d. Date signed (Month, Day, Year)

21532

May 10, 2010

29c. License number

4 Broadway Street,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Esther Month Fader 8 3:14 p^M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🗗 F Months Days Hours (Month, Day, Year) 04/08/1934 New Jersey Director 150-28-8038 76 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 31851 Quail Ridge Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Church of the Nazarene evangelism ministry Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname)
 Mary Emma Rickenbach Clarence Newton Monnett 19a. Informant's Name/Relationship (Type, Print) Rev. Wesley R. Fader/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31851 Quail Ridge Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore of MD Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/14/2010 Hurlock, MD 4 Donation 5 Other (Specify) 1. Signature of Fun val Service Licensee Holloway Fuenral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 -0 X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant a Pregnant at time of death Yes 2 No the Unknown r signed by trid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate Yes After this certification funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 140 မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Il Director: A Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) Y))) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgley Ave., Suite 121, Annapolis, MD 21401 Ira Weinstein, M.D. 31. Date filed (Month Pay), 1eg 2010 32 Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > \(\cap\$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ C. Month Helene Fisher Leroy 2:15 P M 2010 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Country House Residence Cumberland If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 X F 94 Director 214-05-7377 06/08/1915 West Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 12806 Old Church Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Mantal Status 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 No ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Clower Clyde Blanche Parker Goldsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11412 Kemp Drive, Frostburg, MD Jack P. Fisher / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 05/13/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition resulting in death) 2month Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown jo Month Year 5 Other (specify) Day Pregnant at time of death detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Spe Assisted 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.
the Funeral Director: Aft
impleted filled in by the fur 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the comple

Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

> womedelle

MAY

Wonsock Shin, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

32. Registrar's Signature

29c. License number

925 Bishop Walsh Road, Cumberland, MD

D0055325

29d. Date signed (Month, Day, Year)

21502

May 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:00 AM Michael John X 2010 MAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22111 Wetipquin Road Ouantico Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Min. Days Hours 1 **X** M 2 □ F Director 158-66-6146 49 Yrs 06/27/1960 New Jersey Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 K No Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21856 22111 Wetipquin Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) boat builder Silverton Yachts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked or
any injury or other traumatic eve 2 Robert Meeker Horton Goldie Estell Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Horton/son 649 Buck St., Millville, NJ 08332 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 St Cremation 3 Removal from State emetery, crematory or other place) 5 12 2010 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association Dompson 501 Snow Hill Rd., Salisbury, MD 21804 > CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death been signed by the same should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Hospital 2 🗌 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signa 29d. Date signed (Month, Day, Year) H5049)

Registrar DHMH 17 Rev 7/2009

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P.O.

100 E Carroll St

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ompleted cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

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Box

P.0.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Hughes, Jr. Month William 65 OPM 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital amoll Westminster amol If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 37-48-4846 (Month, Day, Year 1 X M 2 🗆 F 15 North Cultina Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumaft event, the Medical Examiner must be notified at any injury or other traumaft event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster MD Camoil 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Glenbrock Onve 21158 U-7- W. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) anstruction Equipment perator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hughes KIMPAR Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henbrook Drive Westminster. Wanda 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Jefferson Free Will Baptist Church Lem. 12, 2010 21. Signature : Euneral Service Licenses 22. Name and Address of Facility Wettel Funeral Home and Crematory .Inc. 549 Carlish St. Hanney PA 17331 rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hevere disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s performed death? Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 70 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. WILL cause of death (Item 23a) (Type, Print) East nam shreet Hospien de O 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Walden David Hall 2010 2:58P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel <u>Medical</u> Center <u>Annapolis</u> <u> Arundel</u> Anne Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours Min. Month Bay Director 213-14-3958 89 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1730 Underwood Rd. 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 2 No 1944 Completed by 1 Never Married 2 Married 1X Yes If Yes, Give Maryland 21215-0036 1946 1 Yes 2 X No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) iron worker steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Christopher Hall Carrie May Hargett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108910 Courtland Manor Rd . , Millersville, MD Linda Schreier (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery 5/14/2010Middletown, MD 4 Donation 5 Other (Specify) Sign dure of Fund J Service Licens Donald B. Thompson Funeral Home Musil POB 18 Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a car sequence of): Medical Examiner Sequentially list conditions, any, leading to intrinediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending a function of the continuous and t Exam burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director: After this certificate 1 🗌 Yes 2 🗌 No Se-Yes completed filled in by the funeral director, Certificate: To Be 25. Was case referred 26. Place of Death (Check only one) examiner? 2 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title 29d. Date signed (Mghth, Day, Year) 8 MA

Registrar DHMH 17 Rev 7/2009

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State

30. Name and address of

31. Date filed (Month, Day,

son who completed cause of death (Item 23a) (Type, Print

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32. Registrar's Signature

BASSAM

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Milton Emmett Higgins Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jorches, If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 13, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 x M 2 □ F 214-32-5910 76 Ĩ933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 ☐ Yes 2X ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4888 Drawbridge Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1952-56 1 Never Married 2 Married white 1 ☐ Yes 2 🙀 No Specify. 3 ☐ Widowed 4 🔀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) police officer natural resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Lee Higgins Ida Lillian Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Johnson sister 4888 Drawbridge Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Crematory of Delmarva 5/10/10 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ischeaute condismyspathy (couprotine Due to (or as a consequence of): arthur E squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as of onsequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown condiouente 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HTH. Hypulindewra 25. Was case referred to medical examiner? autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Marrher of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

attending physician and

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after death Director:

24 hours a

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Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

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filed within 72 hours

Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai once.

or other traumatic

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Pages 1 and 2 should

altimore,

Division of Vital Records, P.O. Box 68760,

event, the Medical Examinar must be notified at

Director

Funeral

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Be Completed

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Examine Physician/Medical þ Completed Be Certification: To

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of ce fifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 165076

29d. Date signed (Month, Day, Year) 5.8.10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRISTIAN VILCU 31. Date filed (Month, Day, Year) MAY 10

32 Registrar's Signature

503

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

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Byrn SL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Harry Henrv Harding 2010^{ar} 2:26 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cambridge Examiner County of Death Dorchester Mallard Bay Care Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 X M 2 D F Months Hours 219-14-3794 85 Director Sept. Mary Land Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at Director 10c. City. Town or Location 10d, Inside City Limits MDDorchester Vienna or 28a-f 1 🗌 Yes 2 🕱 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 2314 Elliott Island Road 21869 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' 9 Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 No If Yes, Give 1 (72 hours after Baltimore, Maryland 21215-0036 "natural", res, Give Year or Dates. 1945–46 1 Yes 2 No Specify: white Completed 3 🗌 Widowed 4 🔀 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 10 plumber home improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Henry Harding May Florence Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chet Martinek 2232 Elliott Island Rd., Vienna, MD p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/13/10 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Arteriosclerar shock, or heart failure. List only one cause on each line Immediate Cause (Final Corditralcular detech Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** -YOU'C if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (ck only one) 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Praction of T. The best of my knowledge at all program day the line. The best of the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 40 47924 + vet

State Registrar

503

Registrar's Signature

34RN SE CATARIDAE MD 21617

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANGT

NOMAN

31. Date filed (Month, Day, Year)

NAY 1 1 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 16341

		1- For State Cell Wally Idina / Department Cell Registrar	rtificate of Death			g. No.	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Jose Ernesto	o Chicas Irahe	ta	2. Date of Death Month	Day Year	3. Time of Death 0323 hrs
iviedicai Examii	lei	4a. Facility Name (if not institution, give street and number)		or Location of Death	May 9, 201	4c. County of Deal	
		New Hampshire Avenue & Piney Branch Road	Langley P	Park		Prince Georg	e's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. line) 1 M 2 F 3 Usual Residence of Decedent		ear If Under 24Hrs Days Hours Min	_	h(MM/DD/YYYY) 9. Bi Forei /1980	
any	ı		Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ō		Silver Spring				1 X Yes 2 No
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imore, MD 21215-0036 Pages I and 3 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last) Santos Chicas		18.Mother's Name		,	
2121 2121 Mental Marke	To Be	19a. Informant's Name/Relationship (Type, Print)	Laura Iraheta r Rural Route Number, City or Town, State, Zip Code)				
MD 12 shorth and 27 is umatic	- 1	Maria Carmen Cruz Chicas (Wife)	1020 Ouebec				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	- [21. Signa of Funeral Service License		, Kei	ndon/Hal	e Funeral .	Home
Physician	\dashv	23a Part I. Enter the disease or complications that caused the death.	9013 Annar Do not enter the mode of dyin				Approximate Interval
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on of V ending Phy sath. or: After th	ition: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) May 9, 2010	28b. Time of Injury 28c. In	njury at Work?	28d. Describe ho	ow injury occurred or vehicle collisio	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	ome, farm, street, factory, office		or Town, Sta	ate)	ral Route Number, City ch Rr., Langley Park,
he Hor in 24 h he Fur pletely		29a. Certifier 1 Certifying Physician: To the best of my knowledg (Check only one) 2 W Medical Examiner: On the basis of examination are		·			
Tot with Tot com	Medical	and manner stated. 29b. Signature and title of certifier		nse number		29d. Date signed (Mo	
		Careal Hallain -	0.0	C.M.E.		May 9, 2010	
0 2	ŀ	30. Name and address of person who completed cause of death (Item					
R 3			111 Penn Street, Baltir	more, MD 2120	1		
Sta Registr	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	Par .				

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	Physicia	an/	1. Decedent's Name (First, Middle, I	•					2. Date of De		lav Year	3. Time	of Death
	Medic	cal	Dorothy M.	Jackson					May		11, 201		9A M
البسور	Examir	ner	4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital Center 4b. City, Town, or Location of Death Clinton Prince									es	
	Funeral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	9. B	irthplace (State	or Foreign
	Director		214-82-0224 1 M 2 X F 63 Yrs. Months Days Hours Min. Min. Month, Day, Year) Country Maryland Usual Residence of Decedent										nd
	and show lat	ē	10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside 0	City Limits
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	th the 3a or t be n	a D	10e. Street and Number				10f. Zip Code	_		10g. C	itizen of What C	ountry?	
	ath wi	Funeral Director	21652 Forrest D	12. Was Decedent B	ver in U.S.	13 W	2065		Specify Vos ar No		USA		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 🕅 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗔 Divorced	Armed Forces?	No		Yes, specify Cub		Specify Yes or No- erto Rican, etc.)		14. Race - Am Black, Whi Specify: B	te, etc.	
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ē,	of Heal		Francis Jackson 20a. Method of Disposition		20b. Pla	ice of Dispos	ition (Name of		jemoy,MD		0662 Location - City o	r Town, State	
Ē	Page 1 ment of ant: If it ury or o		1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 4 \square Donation 5 \square Other (Spe	☐ Removal from State ecify)			atory`or other place Baptist		7/2010	Na	anjemoy,	Maryla	nd
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-	Examiner		resulting in death,	Due to (or as a	a consequer	nce 1:							
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	tificate be executed ng physician and as the burial-transit	xam	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
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09/8	tificate k ng phys as the l	Medical		d									
Rox ea		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of the state of the sta	2 🗌 Fetal c	death 3 🗌	Ectopic pregnand Other (specify)	су			23d. Date of de Month	•	Year
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	he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 Medical Example (Check 2 Medical Example)	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination a	nd/or investig	ation, in my opinic	on, death occurred	at the time, date a	nd place	e, and due to the	cause(s) and ma	anner stated.
_	Voith Com		29b. Signature and title of partifier	~ (4.5)			29c, License			29d. Da	ite signed (Mont	h, Day, Year)	
			7/100	V~U				55120		/8/ A	4 11 20	110	<u> </u>
1	383		30. Name and address of person who Rich ADD Palme V					O Washi	as han De	2003	2		
	Stat Registra	е	31. Date filed (Month, Day, Year)	2010 32. Fegistra	's Signature	. Sa	west.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		artment of H		and Me	ental Hyg	iene			
			Registrar 1. Decedent's Name (First, Middle	(act)		Cer	tificate of D	Deatn	Т,	P. Date of Deat	eg. No. 2	10	16343	
	Physicia				nings				2	Month	Day	Year	3. Time of Death	
L	Medic Examin		4a. Facility Name (if not institution				4b. City, Town, or Location of Death				4c. County of Death			
			Prince George'	s Hospital	Cente	r		ever1			Prin	ce G	eorge's	
	Funeral Director		5. Social Security Number 220–70–4900	6. Sex 7 1 🔀 M 2 □ F	. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth		9. Birthp Coun	place (State or Foreign try) DC	
	d t	_	Usual Residence of Decedent 10a. State 10b. County		10a Cib	y, Town or Loc	nation						0d. Inside City Limits	
	arylan a-f sh ified a	Director		ce George's		y, lowil of Lot		t Was	hinat	On		- [1 🔀 Yes 2 🗆 No	
	or 28 e noti		10e. Street and Number	ce George	P		10f. Zip Code	t was	minge	10g. Citizen of V			ntry?	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eximiner must be notified at	Funeral	8411 Bella Vi	sta Terrac	e		20	744			Un	ited	States	
		Fur	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cut				Vas Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Specify , Puerto Ric	y Yes or No- can, etc.)		- Americ	an Indian,	
36		d by	1 ♣ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:						I	Afr			
21215-0036	hours natur dical l	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation						ada dila a		16b. Kind of Bu	_	cican dustry	
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	ed with Hygier other i	l o	7. Father's Name (First, Middle, Last)						8. Mother's Name (First, Middle, Maiden Surname			Priva	ite	
Maryland	be file ental l rked o ic eve	2							oria Ba		,			
ary	should and M is mai		19a. Informant's Name/Relations			19b. Mailin	g Address (Street a	and Number	r or Rural R	oute Number,	City or Town, S	tate, Zip C	Code)	
	Tammie L. Jennings/ Sister 6025 Sirenia								Wal				0603	
Baltimore,	m		20a. Method of Disposition 1 Burial 2 Cremation		tate 20b. P	Place of Disportementery, crem Harm	sition (Name of natory or other place Ony		May 1	å,	20c. Location -	•		
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120	icate l g phys	ledical		d										
Box 687	n certifi ending	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ncy I death 3	Ectopic pregnanc	v			23d. Dat	e of delive	ery	
Bo	death the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		int at time of d		Other (specify)	,			Mor	nth	Day Year	
P.O.	at the ed by t detach		Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use contri	bute to th	ne cause of death?	
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The condition of the first of t										24a. Was ar		Vere autop	osy findings available mpletion of cause of	
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o uc	nding ath. :: Aftel e fune	icate	1 Natural 5 Pendir 2 Accident Investig	g (Month,	Day, Year)	injury	work'			2. Describe no	w injury occurre	u		
visio	r Atte ter de rector	Certificate:	3 Suicide 6 Could 4 Homicide determ	inca 28e. Place of	Injury - At ho	me, farm, stre	et, factory, office		28f		reet and Numbe	r or Rural	Route Number,	
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	To th Withir Comp	2	29b. Signature and title of certifier				29c. License	number		2	9d. Date signed	(Month, L		
)		mu Kemil A				000	540	181		5/5/1	0		
12	3		30. Name and address of person of Muke mil	who completed cause	of death (Item	23a) (Type, P	rint) 001 Hospi	ital T)rive	Cheve	rly. Ms	rv1s	nd 20785	
	Stat	e	31. Date filed (Month, Day, Year)	32. Reg						2		7 0		
	Registra	ar	MAY 1 2 2010	(Centra	p. 19	- au								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Irvin н. Kelley 2010 5:22AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 30562 Cannon Drive Wicomico Salisbury 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F 0672371942 Maryland Director 221-26-5910 67 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30562 Cannon Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Army Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Ş Kelley, Trvin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", white Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 welder welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Irvin Kelley Eunice Marie Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health as
Important: If item 27 is
any injury or other trans Jeanie Kelley/spouse 30562 Cannon Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cametery, crematory or other place)

Fastern Shore of MD

Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 | 13 | 2010 Hurlock, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISRASR ARKINSON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been siç page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed² To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature ar title of certifie 29d. Date signed (Month, Day, Year) 005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 thurs WAR RO

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Irene Lassiter Kinnish 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Berlin Worcester 13 Brittany Lane Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Min. 1 M 2 X F Hours 4 (Manth 192 Year) 228-34-7759 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13 Brittany Lane 21811 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married 1 Yes : 2 XNo 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced Completed white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Navy Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Claude Lassiter Emma Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Benjamin Kinnish / 11925 Appaloosa Way, Gaithersburg MD 20878 son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lakemont Memorial Cem! 5/13/2010 4 Donation 5 Other (Specify) Davidsonville, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of upera Septice Licenses 108 William St., Berlin, MD 21811 23a. Part / Enfer he disease, or complications that car shock, or heart failure. List only one cause on each Immediate Cause (Final the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical e to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attendion abusing and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached fir use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only which g Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 РМ May 3:49 Patsv Irene Keenev Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 7433 Franklinville Road Thurmont 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Davs Hours (Month, Day, Ye Country) Maryland Director 71 215-36-6156 Mar. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filled within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🎦 No Marvland Thurmont Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 United States 7433 Franklinville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes, Give 3 Midowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Allen Benjamin Holt Alice Elizabeth Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fairfield, Pennsylvania 17320 Benjamin D. Keeney / Son 28 Walnut Trail May 1. 2<u>010</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ΪΊ, cemetery, crematory or other place 9 1 Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Resthaven Mem Gardens Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Thurmont, Maryland 21788 104 E. Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final metastatic to liver + bore Physician 1 Cue oma ð disease or condition resulting in death) month Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 24 hours after death.

Funeral Director: After this certificate has 1 Yes 2 No 25. Was case referred to edical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 52 WATER ST. THURMONT BRAD m.D. 15

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cecil Gene Kergan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex. 1 M 2 □ F . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 220-32-2684 September 02, 1934 Maryland Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 🗌 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Ormand Street Funeral 21532-12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 192
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 2 No 1455-Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced 1957 Year or Dates White and Mental Hygiene.
Is marked other than "natur raumatic event, the Medical ! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) draftsman ballistics laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Cecil Kergan Helen Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Darlene Kergan 112 Ormand Street Frostburg Maryland 21532-Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland May 06, 2010 Maryland 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Betweer Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequent e of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 - No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

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E-NATIONA

32. Registrar's Signature

AVALE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

hanna

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		, ,	For State Registrar		of Marylan	•	artmen rtificat			and M		Reg.	0.0	0.10	1.6	34	: 8
	Physici	an	1. Decedent's Name (First, Middle	, Last)	7.7						2. Date of Month		Day	Year	3. Time o		
	/Medio		Elva			tterma			1 1'	1 D = -15	May		2010	D th	6:15	A	М
) 	Examir	ner	4a. Facility Name (If not institution Golden Living	Center		In a thirth day	4b. City,	Cumb	Location of the Control of the Contr	nd	0. Data at				egany	ou 50 to	
h	Funeral Director		5. Social Security Number 213-64-8849	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 93	Yrs.	Months	Days	Hours	Min.	8. Date of (Month)	Day, Ye		Coui	Virg		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	10d. Inside (City Limi	its
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deat Evanitar must be traffic death	ctor	MD All	egany		Cumbe	rland								1 ☐ Ye	s 2 ∏ N	10
		Director	10e. Street and Number 11105 Forest Avenue, NE 21502							10g.	Citizen of	What Cour	ntry?				
		Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Dece				ecify Yes o	No-		ice - Ameri	can Indian,		
36	s after (by Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe						Rican, etc.		Speci	ack, White,	etc.				
21215-0036	hours tural'		3 ☒ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)								16b	b. Kind of E	W] Business/In	hite dustry			
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7	filed withii Hygiene. Ither than	Sol	8 Cook								taura	rant					
Maryland	tal do	Be	17. Father's Name (First, Middle, Hendron	Last)		terman Sterma r	1		18. Mothe		(First, Mic	ldle, Maid	den Surna	_{me)} Morra	al		
ary	she m	To	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address	(Street a	and Numb	er or Rura	l Route No	ımber, Cı	ity or Towr	n, State, Zip	code)		
Ξ,	2 = 21 +		Richard Ketterm	an / Son											stone,	MD2	15
ballillore,	t. Pages rtment of rtant: If ii		20a. Method of Disposition 17 Burial 2 □ Cremation	3 Removal from	i State I	Place of Dispo cemetery, crer					ate		Country or Town, State				
			4 Donation 5 Other (S)		Sur	nset Me									· .	РΛ	
מ	permi Depar Impo any ir		21. Signature of Funeral Service Cicensee 22. Name and Address of Facility Adams Family Funeral Home 404 Decatur Street, Cumberland, MD 215										21502		•		
	Physician / Medical Examiner the private transit private tran	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to	o (or as a consequence) (or as a consequence) (or as a consequence)	juence of):	ile 1	vige	Car	do	J <u>J1</u>	Ya	-elw	~	30 v	nli	1
	or Attending Physician: The law requires that the death certificate be executed affer death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown											ate of deliv	rery Day	Year	
2	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying o	ause give	en in Part I				co use coi		the cause of bably 4		
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A III	sician: The certificate I rector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe			n <i>(Check</i> oi						
5	ding Phys h. After this funeral dir	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date	Inpatient 2 e of Injury nth, Day, Year)	28b. Time o Injury		28c. Injury Work	44270		me 5 🗌 I 28d. Descr			ther <i>(Speci</i> irred	ify)		-
DISION	al or Attendi s after death. Il Director: A ed in by the fu	Certification:	3 Suicide 6 Could in 4 Homicide determ	not be 28e. Plac	e of Injury - At h ding, etc. (Speci	L ome, farm, str fy)	reet, factor	y, office			28f. Location City of	on (Stree Town, S	et and Num State)	nber or Run	al Route Nu	mber,	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier (Check only one) Certifyir 2 Medical	g Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to	the caus me, date	se(s) and r and place	manner as e, and due t	stated. to the cause	(s)	
	Vaithi To t	Σ	29b. Signature and title or certifie						e number	30.					Day, Year)	7	
	20		, 7	hophro					333				Man	14	2011)	
			30. Name and address of person Sunil K.	wholcompleted cat Gupta, M.	D., 62	n 23a) (Type, 5 Kent	Aven	iue,	Cumbe	erlar	nd, MI	2	1502				
	Sta Registi		31. Date filed (Month, Day, Year)	5 2010 32.	Registrar's Signa	d. A	barke	,									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George T. Komatz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Allegany Cumberland Western Maryland Regional Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 21, 1918 Social Security Number . Age (In yrs, last birthday, 9. Birthplace (State or Foreign **Funeral** Days Maryland Director 217-07-2177 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10601 Komatz Drive Funeral 21532-U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 V No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🜠 No Specify: If Yes. Give Specify: Completed 3 Widowed 4 ☐ Divorced White Year or Dates. er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Brick Maker refractory is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anton Komatz Martha Bollinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau 21532-Barbara Knotts Daughter 10614 Komatz Drive Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens May 04, 2010 LaVale Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE Pul. DISEASE Onset and Death Immediate Cause (Final SEVERE CHRONIC Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗷 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 30, 20/0 in 3

State Registrar umberland

SetoN

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Newton Eugene Love MAY 2010 11:25A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5/3/1924 5. Social Security Number Funeral Days Hours 1**X** M 2□ F 86 225-18-8095 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mardical Examinal must be notified at MD Frederick Myersville 1 ☐ Yes 2 No Director 10452 Highland School Rd. 10f. Zip Code 10g. Citizen of What Country? 21773 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🛛 No SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) machinist metal co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stewart Franklin Love Virginia Dickerson 19a. Informant's Name/Relationship (Type. Print)
Lois J. Love (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $2\,1\,7\,1\,3\,1\,04\,5\,2\,$ Highland School Rd $_ullet$, Myersville, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2 ☐ Cremation 3 ☐ R on 5 ☐ Other (Specify) 1 X Byrial 3 Removal from State Lutheran cemetery 5/8/2010 Middletown, MD 4 Donation 81grature of Donald ddd B. Thompson Funeral Home POB 18, Middletown, MD 21769 e, o complications List only one cause eart failure. art 1. Ente at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tinos clustic Cendis Varaly 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Millitter Centro Variata Accide 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an mell- injuck dimenti 1 Tyes 2 No 1 ☐ Yes 2 4No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed and Box 68760. attending physician P.O. Records, certificate of Vital Hospital or Attending Physician: Division death.

Baltimore, Marylánd 21215-0036

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signed by the a cate has by page 2 s

hours after death uneral Director: / within 24 hours aft

To the Funeral Di

completely filled in

To the 1 within 2 To the 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

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and manner stated.

Lenson

340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 VASANT DATTA, 31. Date filed (Month, Day, 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D18015

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Helen May Lent May 6, Medical 2010 3:30 p. M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2626 South Everly Drive Frederick Frederick **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 M 2 X F 9. Birthplace (State or Foreign Director Hours Months Days May 27, Year 920 Missouri Usual Residence of Decedent or 28a-f shov and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County Director 10c. City, Town or Location Maryland Frederick Frederick 1 🗷 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 2626 South Everly Drive 21701 "natural", or items USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 KNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black, White, etc. If Yes, Give Year or Dates. 3X Widowed 4 ☐ Divorced Completed 1 ☐ Yes 2 X No Specify: white Specify: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 27 is marked other than traumatic event, the Me (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dwight Edwin Whitehill Eula Lee Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Hayman -2626 S. Everly Drive, Frederick, Maryland daughter injury or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dpnation 5 Other (Specify) Sewickley Cemetery 5-11-2010 Sewickley, Pennsylvania Sign Jure of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Interval Retween Coronney disease or condition nset and Death HEART Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical · Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicisted filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPER CIPIDEMIA, HYPERTENSION, OSTEOPOROSIL 1 Probably 4 Unknown TEMPORAL ARTERITIS, COMPRESSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 🗗 No 1 🗌 Yes 25. Was case referred to medical æ examiner? 26. Place of Death (Check only one) Hospital: ၉ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending injury Accident
Suicide
Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ne loon DZ1936 10 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

10

. DONELSON MD

31. Date filed (Month, Day, Ye

JOHN SON

ack

FREDERICK,

21702

, BSC THOMAS

32. Registrar's Signature

		1 - State Registrar Certificate of Death Reg. No.									
		1. Decedent's Name (First, Middle, Las	st)					2. Date of Death		3. Time of Death	
Physicia Medic		Beulah	Amanda		Leedy		Month May 1		Year	8:30 A ^M	
Examin		4a. Facility Name (if not institution, give Sincerely Yours	street and number) Assisted Livin	ng	4b. City, Town, or Cumber 1		4c. County o	f Death gany	-		
Funeral Director		5. Social Security Number 6. S 219-14-6632	ex 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	11 011001 0	Hrs. 8. Date of Bi Min. (Month, D 04/28	rth ay, Year) / 1922	9. Birthpl Cou <i>nti</i> Virg	ace (State or Foreign ry) inia	
, M		Usual Residence of Decedent	140 00								
Maryland 28a-f sh	rector	10a. State 10b. County MD Alle	egany 10c. City,	Town or Loc	cumberla	nd			10	0d. Inside City Limits 1 Yes 2 No	
with the s 23a or 2	Funeral Director	10e. Street and Number 512 Marietta S	Street		10f. Zip Code	21502		10g. Citizen of Wh		ry?	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Plygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates.	lf lf	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)		White, et		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed by	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give k life. DC	ent's Usual Occup- ind of work done of NOT use retired)	luring most of	f working	16b. Kind of Bus			
d with dygier ther t	Be C	12		Ch	nief Cler			Chief	of F	olice	
yland Id be file Mental H arked of	To B	17. Father's Name (First, Middle, Last) Ira	Smith			18. Mother's Edit	s Name <i>(First, Middle</i> Ch		_ease	}	
		19a. Informant's Name/Relationship (7) Robert W. Messme		19b. Mailing 2 Bro	g Address (Street a ookstone	Court,	or Rural Route Numb Luthervi	er, City or Town, Sta .lle, MD	te, Zip Co 2109	ode) 3	
Baltimore, I bermit. Page 1 and 2 Department of Healt mportant: If item 2 any injury or other:		20a. Method of Disposition 1 X Burial 2 Cremation 3 C		ce of Dispos	sition (Name of latory or other plac	e)	Date	20c. Location - C	ity or Tov	vn, State	
timo t. Page tment o tant: If ijury or		4 Donation 5 Other (Special	(y) MD	Vet Ce	em @ Rock	y Gap	05/13/201	0 Flint		ne, MD	
Bal permi Depar Impo any ir	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Vet Cem @ Rocky Gap 05/13/2010 Flint 22. Name and Address of Facility Adams Family Funer 404 Decatur Street, Cumberland, N										
Priysician/		23a. Part X-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition A Low Sclant C Card of a Sucrement of Sucrem								Approximate Interval Between Onset and Death	
Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):						7	
ted nsit	Examiner	Sequentially list conditions, if any leading to in model cause. Enter Underlying Cause (Disease or linjury	Directo (or est a consequer	nce off:							
be execur sician and burial-tra		that initiated events resulting in death) Last	Due to (or as a conseque	nce of):			· · ·				
68 / 60 ertificate k ding physise as the k	/Medical		d								
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of the second	death 3 🔲	Ectopic pregnanc Other (specify)	У		23d. Date Mont		ry Day Year	
IS, P.O	ρ	Part II. Other significant conditions of	ontributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.		tobacco use contrib		e cause of death? ably 4 Unknown	
VITAI KECOrdS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed							psy pri ormed? de		sy findings available apletion of cause of	
al Fian: Tian: Titilica	BeC	25. Was case referred to medical examiner?			26. Pla	ace of Death ((Check only one)	2 120 140 1 1			
hysic hysic his ce	၉	1 ☐ Yes 2 ☐ No	Hospital:			4 🗀 Nursi	ing Home 5 Resi			Assisted Living	
on of ending F eath. or: After the funera	Certificate:	27. Mann Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	8b. Time of injury	28c. Injury work M 1	rat ? Yes 2 □ No	1	how injury occurred			
DIVISION OF tal or Attending Pr rs after death. al Director: After tt ed in by the funera		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To	Street and Number vn, State)	o <i>r Rural F</i>	loute Number,	
ne Hospi n 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Exam	sician: To the best of my knowled ner: On the basic of examination a se Practioner: To the best of my k	and/or investig	gation, in my opinio	n, death occur	rred at the time, date	and place, and due to	o the caus	se(s) and manner stated.	
Within Within Committee of the the		29b. Signature and title of certifier			29c. License	number 6766		29d. Date signed (I		**	
noh.		30. Name and address of person who d	completed cause of death (Item 2	3a) (Type, Pr	rint)						
		Vik Poona 31. Date filed (Month, Day, Year)	i, M.D., 924 S		Drive, Co	umberl <u>a</u>	and, MD	21502			
Stat Registra		MAV 1 1	32. Registrar's Signatur	U	13 Market						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LAFFERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMRMC ALLEGAN UMBERLAND 5. Social Security Number 6, Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 **Ø** M 2 □ F (Month, Day, Year) 28 185-24-373 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director BEDFORD BUFFALO 1 Yes 2 No MILL 10f. Zip Code 10g. Citizen of What Country? Funeral GARDEN USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 🛣 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: I Hygiene. other than "natural", Specify: White 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LABORER STATE OF is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EUGENE LAFFERT and Mental MILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR 1 and 2 s of Health item 27 i BUFFALO MILLS HELEN L. LAFFERT injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place)
MADLEY CEMETER Y 1 M Burial 2 Cremation 3 M Removal from State 4 Donation 5 D Other (Specify) 5-10-2010 Buffalo Mills 21. Signature of Funeral Service Lice 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERIAL HEMEINC 169 Clarence St HYNDMAN PA 15545 The 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) Examiner SCONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page SPOSSS certificate 1 Yes 2 No ☐ Yes 2 🔀 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital |@ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 47 D31875 DOSENT 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 WILLOWBROCK RD CUMBERLAND MO 21502 ROBERT WELTK, MD 31. Date filed (Month. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** awson onZo /Medical 28 4c. County of Death 1:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Easton

Juder 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day,
(1) Ct. 13 Genesis Health Care-The Pines Talbot Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-70-86 50 1 1 M 2 □ F 52 Months Director Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Marylar 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examitar mant terms filled at 1 Yes 2 No Directo Caroline Federalsburg Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 ₹ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paving 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Lawson ပ George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Central Ave. Federals burg MD 2/10
Date 20c. Location City or Town, State Darlene MD 21632 Haynes injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 11/10 4 ☐ Donation 5 ☐ Other (Specify) Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOME, PLA HENRY Funeral Sti Cambridge, 23a. Print. Enter the disease, or complications that caused the death. Do not enter the mode of dying, with as cardiac or respiratory arrest, in ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LING MACI GNANT MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or se a consequence of) been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 100 1 ☐ Yes 1 TYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Gursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 2 ☐ No 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. Certifying Nurse Practitioner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R133336 APRIL 28 ZOID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUSI NP 31. Date filed (Month, Day, Registrar's Signat State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

altimore,

Division of Vital Records, P.O. Box 68760,

Alonzo Lawson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year 9:40 AM Month **Physician** 2010 MICHAEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F 225-84-2731 /5/1958 Richmond, VA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1

Yes 2 □ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 10820 Vista Garden 20720 United States Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 🗌 No 1 ☐ Yes 2 😿 No ģ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Software Engineer Manager Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Bell Lynch ၉ Joseph Bennett Sims 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23019 Telegraph Rd. Ruther Glen, VA 22546 Annie Bell Fox / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico National 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 14,2010 Triangle, Va. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatur of Funeral Service Licen 0101085 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death Part 1. Finer the disea shock, or heart failure at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part disease, o complications to failure. List only one cause Immediate Cause (Final Cholongio Carcinomo disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 2189SC Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3

Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 / 0 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner**

Funeral

Director

28a-f show

ral", or Items 23a or 28a-f sho Examiner must be notified at

"natural",

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and Mental I

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

the Medical

or other traumatic event,

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

ician and burial-transit

Hospital or Attending Physician: The law requires that the death certificate
4 hours after death.
Funeral Director: After this certificate has been signed by the attending physi
tely filled in by the funeral director, page 2 should be detached for use as the

Division of Vital Records, P.O. Box 68760,

within 24 10 Registrar

State

Medical

1 Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (check only 29b. Signature and title

5 Pending investigation

Could not be

determined

MP

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES -000

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

May

31. Date filed (Month, Day, Year) 2 2010 MAY 1

2 Accident

4 Homicide

3 Suicide

32. Registrar's Signature

MO

(Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State C	of Maryland		artment of F <i>tificate of L</i>		Mental Hy	giene Reg. No.	010	16356
Physicia		1. Decedent's Name (First, Middle, Last) Virginia D. Mes	ssick				2. Date of De Month	ath Day	Year 2010	3. Time of Death
Medie Examir		4a. Facility Name (if not institution, give street and nur Tens NSULA REGIONAL Medica	nber)	/		Location of Death		4c. Count	y of Death	
Funeral Director		5. Social Security Number 214-28-8356 1 □ M 2 🗷 F	7. Age (In yrs. last 94	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 08/23/	th	9. Birthp	place (State or Foreign
yland •f show ed at	iţo	Usual Residence of Decedent 10a. State 10b. County	,	Town or Loc					1	0d. Inside City Limits
ite; INTAILYIGHTU ZIZIO-0000 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Wicomico 10e. Street and Number 9288 Hickory Mill Road		isbur	10f. Zip Code 21801	-		10g. Citizen of USA	1 ☐ Yes 2 🛣 No	
s after death ral", or item: Examiner m	by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decreased Formula 1: Was Decreased Formula		l If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, c	
ithin 72 hour ene. • than "natul the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)				ing	16b. Kind of E		dustry	
Vidi yidiild ZIZIX 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) John H. Davis 18. Mother's Name Winnie						Maiden Surnam	ne)	
od 2 should ealth and h n 27 is me er trauma		19a. Informant's Name/Relationship (Type, Print) Gerald Messick/son		195 Mailin 3811	3 OId St	and Number or Rur age Rd • ,	Delmar,	"ÖE″199	State, Zip C	Code)
permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place	ce of Dispos Petery (rem Garde	sition <i>(Name of</i> P ^I P ^{ry} Methor Pey PNS	5/11	Date /2010	20c. Location Hebro	- City or To	
permit Depart Impor any in		21. Signature of Furferal Service Licenses	mel	· 24	Name and Address OI Snow	Füheral H	Home Pro	fession ury, ML	al As 2180	sociation
Ph_sician/ Medical		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on earn mmediate Cause (Final disease or condition resulting in death)	caused the death, ich line. (or as a consequer		,		or respiratory ar	rest,		Approximate Interval Between Onset and Death
Examiner	er	Georgia Hat Congruence	or as a consequer (or as a consequer		el level	fall				
cate be executed physician and sthe burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c	or as a consequer							
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the death on the atternation of the atternation ached for u	Physician/M	in the past 12 months?	Birth 2 ∐ Fetal d nant at time of dea nown		Ectopic pregnanc Other (specify)	у				Day Year
requires that the de-	by	Part II. Other significant conditions contributing to d	eath but not result	ing in the ur	nderlying cause giv	en in Part I.		• •		e cause of death?
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Attending Physer death. ector: After this by the funeral di		27. Manner of Death 28a. Date	of injury 28 th, Day, Year)	3b. Time of injury	28c. Injury work	at	28d. Describe h	iow injury occur	red	
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place buildi	of Injury - At homeng, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb		Route Number,
the Hosp nin 24 hoo the Fune	Medical	29a. Certifier 1 Certifying Physician: To the base only one 3 Certifying Physician: To the base only one 3 Certifying Number Practice.	est of my wowled is of examination are Turns or all of the in	ge, eath or nd/or investi	ccured at the time, gation, in my opinio	ttirre; date and plac	ie, and due to th	causeisFand or	Girinet de 918	thed
vith Con		29b. Signature and title of certifier	The .		29c. License D 5	number HV	0497	29d. Sate Signer		
(LR)	10	3 Naharanji a groupel - Moho o Amazaus Babulal Day. 106 M	e of death (Item 23	Ba) (Type, Pr	int)	alisbur	MI			
Stat Registra		31. Date filed (Month, Day, Year) MAY 1 2 2010	e of death (Item 23	barke	/					

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 10:00 P 1. Decedent's Name (First, Middle, Last) Physician/ May 7, 2010 Irene M. McGroarty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles | LaPlata Charles County Nursing & Rehab Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 - M 2XX July 25, Yello22 West"∀irginia 234 34 1208 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Waldorf Maryland Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20603 United States 10862 Pam Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 **XX**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3√√√ Widowed 4 □ Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) PG County School System Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tennie Cooke Ira Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Maureen Moore (Daughter) 38872 Hidden Pond Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery May 13, 2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral S Ferry Road, Clinton, MD 20735 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or hear failure. List only one cause on each line. Interval Between Interval between Spinset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant Pregnant at time of death signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No 2 Division of Vital funeral director, 26. Place of Death (Check only one) Was case referred to medica Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ne Hospital or Attending Ph n 24 hours after death. The Funeral Director: After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 \square Pending 1 Yes 2 No Accident filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier ဳ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sia nature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 Charles St. La

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2010 11:25A M William Lonie McFetridge, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 4534 Reeves Place, Unit C Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 6. Sex 1 ፟ M 2 ☐ F **Funeral** Days November 8, 1944 Director 577-58-0117 65 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Waldorf Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4534 Reeves Place, Unit C 20602 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Contractor 12 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy E. McFetridge Ralph A. McFetridge permit. Page 1 and 2 should be Department of Heatth and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanyau Warden/Daughter 4534 Reeves Place, Unit C, Waldorf, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 5/15/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee /MQ0945 ²²AREHARTCECHOUS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final BRONCHOGENIC CARCINOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consuguence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 🗌 Yes 2 🔀 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 53885 MD 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 304 WARRE CAMANAN 31 Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day May 9, 2010 3:50 p Louise Holland Morsell 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 115 Pushaw Station Road Calvert Sunderland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 X F March 25, 1928 MD 215-26-3395 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No MD Calvert Sunderland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20689 USA 115 Pushaw Station Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2XNo 3 ☐ Widowed 4 X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 9 Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Holland Annie Wills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 1392, Lusby, MD 20657 Sharlyn Briscoe - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery: May 15, 2010 Sunderland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. Hade 1451 Dares Beach Rd., Prince Frederick, MD 20678 Dervel Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus unleach line. Immediate Cause (Final disease or condition resulting in death) ermone Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery ent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 1 Yes 2 Other (Specify)

Physician /Medical Examiner

Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

Funeral Director

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show lant: If item 27 is marked other than "natural", or items 28a or 28a-f show lany or other traumatic event, I'm Marical Evanting must be notified at ury or other traumatic event, I'm Marical Evanting must be notified at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans attending p for use as t signed by the a page 2 s funeral director. After this after death.

Director: Aid in by the fu

P.O. Box 68760,

Division of Vital Records,

Physician/Medical Examiner þ Completed Be Certification: To

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4 Homicide

in the past 12 months?

			26. Place of Dea	ain (Cit	eck only one)	
ospital: 1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA	Other: 4 Nursing H	lóme	5 Residence	6
28a. Date of Injury	28b. Time of	28c.	Injury at	28d.	Describe how inj	ur

27. Manner of Death 1/2 Natural 5 Pending investigation (Month, Day, Year) 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

М 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Sinle 300 ANWAR MUNSHI.

HOSP RD. PRINCE FREDE

State Registrar

filled in by

completely

Medical

within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year) MAY 11 2010

29b. Signature and title of certifier

ATmund

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O Physician/ May Month Day 2010 Year Charles William McCleary 10 1:15 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charleston Avenue Rose Haven Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 D F Months Days Hours 11/30/1916 579-09-0017 Director 93 Usual Residence of Decedent wouls Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7056 Charleston Avenue 20714 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 metal lather construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles McCleary Florence Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McCleary, wife 7056 Charleston Ave., Rose Haven, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State So. Memorial Gardens 05/13/2010 | Dunkirk, MD 4 Donation 5 Other (Speciff) f Funeral Service Li 22. Name and Address of Facility Rausch Funeral Home, 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ thero disease or condition resulting in death) ces. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed To the Hospital or Attending Privatorian within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my policies, death 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D16823 30. Name and address of person who completed cappe of death (Item 23a) (Type, Print) Robert J. Schlager. MD8924 Chesapeake Ave., North Beach, MD 31. Date filed (Month, Day, Year) 32. Registra s Signature State 12 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001 TLI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Mueller Leo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** 1 □**x**M 2 □ F Min May 13 **Director** 728-07-6778 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Allegany Oldtown 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18107 Malcolm Rd SE 21555 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PPG Industries Laborer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter E. Mueller, Sr. Olive Mae (Shoemaker) Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 18107 Malcom Rd SE Oldtown MD 21555 Helen Mueller wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Sulphur Springs Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 5/4/2010 Kiefer MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Licenses 22. Name and Address of Feculity and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. P x 1. Inter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Physician/ Car Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Day Yes 2 No 9 Unknown as been signed by the 2 should be detached 9 Unknown Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျ 1 🗌 Yes 2 10 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the H within 2-Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific ic erson who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month May Hilda Lee Marshall 5 2010 12:45 a.™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cambridge Dorchester Chesapeake Woods Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 4, 1922 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X 216-82-8888 88 Vrs Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Cambridge Dorchester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1241 Hudson Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of menth of Health and Mental Hygiene.

The 127 is marked other than "natural", or sure If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami. ury or other traumatic event, the Medical Exami. 1 ☐ Yes 2X☐ No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: white 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Spedden Robert Casper 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara L. Peters daughter 1135 Ross Thumb Road, Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Spedden Seward Cem. 4 Donation 5 Other (Specify) 5/8/10 Cambridge, MD 21. Signatur Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. hus lore 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ 529 COngenite disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an has page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 💆 No Other: 1 🗌 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 2 🔲 Accident iniury work?
1 Yes 5 Pending 2 No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier 1 L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number mp

Registrar DHMH 17 Rev 7/2009

State

ERRABOLU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TEEVAN

31. Date filed (Month, Day, Year)

D69234.

BYRN

STREET

10 2010

CAMBRIDGE

MD

21613.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#17.PerFHPGC5-12-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ Patricia Marley Ann 2010 4:44 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Hours June 15, 1943 Pennsylvania Director 196-34-6525 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director Maryland 1 Yes 2XXNo Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7726 Hanover Parkway #104 20770 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★★ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: 3 Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Closer Mortgage Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Marley Matthew Agnes Christine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 Strattondale Ct. Burke, David Morgan / Nephew Virginia 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State May 15,2010 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 21. Signatur of Funeral Service Licer 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE MYO CARDIAL MEARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of if any leading to in redicause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XXNo Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Lynphomo 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Thronbons 24a. Was an page 2 s autopsy performed? Yes 2 X No Thomborey to peuil certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? o 24 hours after death.

Funeral Director: A leted filled in by the full Investigation Accident Accider
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier XXX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Deopu D40324 MAY 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK. TERRY JODRIF, MO, FACEP 7600 CARRELL AUDINUT,

State Registrar

Date filed (Month, Day, Year MAY 1 2 2010

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Alex Vincent Noth		Gel State of Maryland / Department - For State Certificate tegistrar			nd M	ental Hy	_	Reg. No.	20	0 636				
Physicial Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Alex V. Nothnac	је	1			2. Date of De Month April 16,	eath Day	Year	3. Time of Death 2309 hrs				
		4a. Facility Name (if not institution, give street and number)	41	b. City, Town, o	or Locat	ion of Death			County of De	ath				
		Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	<u> </u>	Belair If Under 1 Ye	na 161	Index 24Hrs	In Data of		arford	Citth plans (Chata as Farriage				
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MD 2. d 2 should dith and M m 27 is m aumatic e		Mark Nothnagel 619]	Address (Stree Edgehi	.11	Road	Glens	side	, PA	19038				
Baltimore, permit. Pages I an Department of Hea Important: If itee		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition 1 Vy Hil	othe	er place)			Date 4 / 1 0	Ph:	ilade	or Town, State lphia, lvania				
Salti rmit epartm aports jury o	ı	21. Signature of Funeral Service Licensee 22	2. N a	ame and Addre	ss of Fa	cility Lor	ngwood	d Fui	neral	Home				
	4	Harvey C. Smith Tony (1992)	11:	3 E. B	Balt	imore	e Pk.	KSQ	, PA	19348 Approximate Interval				
Physician /Medical xaminer	î	failure. List only one cause on each line. Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
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Division To the Hospital or Attendit within 34 hours after death. To the Funeral Director: A completely filled in by the file.	<u>न्</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investi				d place, and	due to the ca	use(s) and	manner as s	ated.				
To To con	Đ -	29b. Signature and title of certifier		29c, Licer	nse num	ber		29d. D	ate signed (A	Month, Day, Year)				
		Carol Hallaa		0.0	.м.Е.			April	17, 2010					
3		21 Date filed (14 - 4), Day Van J. 22 Pagister's Cignature		treet, Baltin	nore, l	MD 21201	1							
Sta Registr	~	B1. Date filed (Month, Day, Year) NAY 1 2 2016 32. Registrar's Signature	ar	KN										

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Louise May 6, Mariana Newton 2010 3:26 АМ м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Northampton Manor Health Care Frederick . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min JM1nth 124, 1918 Penngylvania 577-18-1796 Director 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Frederick 10d. Inside City Limits 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Directo Maryland Frederick 1 ☐ Yes 2 No 10f. Zip Code 21703 10g. Citizen of What Country? U.S.A. 10e. Street and Number 5820 Genesis Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical once. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mildred (unknown) Charles Fagan 19a. Informant's Name/Relationship (Type, Print)
Nancy Schmidt, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6814 Falstone Drive, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State National Mem Park May 10,2010 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD - MOIZZZ Frederick, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final olon Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year 1 Yes 2 9 Unknown Pregnant at time of death sate has been signed by the page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Matural work?
1 Yes 2 No 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 6, 2010 dress of person who completed cause of death (Item 23a) (Type, Print) nd a 9093 RidgePield Drive Froderick Md 21701 iarkowski mb 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10°. Physician/ Robert Francis Novy May 20°f6 1:50 ΡМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7786 Arbor Way Calvert Owings 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Ohio Min. 1 🕅 M 2 □ F Hours 285-32-0194 01709/1935 Director Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Owings 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7786 Arbor Wav 20736 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 No X Yes 1 Yes 2 X No Specify: Specify: White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Year or Dates /03/1954 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Communication Manager 12 Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Novy Rose Dziegiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice M. Novy / Wife 7786 Arbor Way, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place. Lee Crematory 1 Burial 2 X Cremation 3 Removal from State 05/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, Signature of Funeral Service Licenses Garpy. Goff 8125 Southern Maryland Blvd., Owings, MD 20736 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 12 tasta disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy performed? Yes 2 N , page certificate I 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical + Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasts or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

drw 10

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

State

Registrar

Jonathan D. Lowenthall, M.D., 110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

10-03297 Ronald Nave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 16368 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Ronald Clyde Nave 0035 hrs April 29, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 216-30-1805 oreign Pennsylvania Months Days Hours 1 X M 2 F 75 Yrs 02/25/1935 Usual Residence of Deceden in y 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. MD Allegany Cumberland 1 X Yes 2 No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1025 Frederick Street 21502 USA Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White etc. 2 X No traumatic event, the Medical Examiner 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. White è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Iron Worker Union 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Albert Nave Be Wilda Hite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic Carolyn L. Nave / Wife 1025 Frederick Street, Cumberland, MD 20a. Method of Disposition Baltimore, permit. Pages 1 and 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Department or Important: I Sunset Memorial Park 05/03/2010 Cumberland, MD 4 Donation 5 Other Specify Signature of Fundral Jer 22. Name and Address of Facility Alams Family Funeral Nome, 404 Decatur Street, Cumberland, MD 21502 act I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Immediate Cause (Final disease a Head Injuries Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Crisicase or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician or use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Month Year Pregnant at time of death 5 Other (Specify) Į, 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available icate has b autopsy prior to completion of cause of r this certificate had director, page ? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other ၉ 1 🗸 Yes After the 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural FOUND: Subject fell down stairs Director: Pending 1 Yes 2 ✓ No hours after death Apr 28, 2010 2 🗸 Accident 2049 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 530 Fayette Street, Cumberland, MD within 24 hours a To the Funeral I filled determined (Specify) Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME April 29, 2010 30. Name and address of person who completed cause of death (Item 23a) 1168-5 Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, State 32. Registrar's Signature Registra

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

10-03498	Please Type or Print in Black I			
Danielle Rose Pai		artment of Health and Mental H	ygiene 201	16369
	Redistrar	rtificate of Death	Reg. No.	
Physician			Date of Death Month Day Year	3. Time of Death
Medical Examine	DANIELLE R. PAIKIN 4a. Facility Name (if not institution, give street and number)		May 6, 2010	0126 hrs
	Sharpsburg Pike at Dunker Church Road	4b. City, Town, or Location of Death Sharpsburg	1 4c. County of Dea Washington	th
Funeral Director		Months Days Hours Min	Fore	ian
Silector	221-80-1427 1□M 2€F 20	Yrs.	July6,1989 0	ountry)Delawar
È	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Limits
_ A				1 Yes 2 No
r death with the Maryland or items 23a or 258s-f sh	Delaware New Castle Ne	wark 10f. Zip Code	10g. Citizen of What Co	1
e Mau or 28s	Toe. Greet and Number			unity?
ith th	13 Deer Run	19711	USA	
ath w	11. Marital Status 12. Was Decedent Ever in the state of	I.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,
er de	1 3	1 Yes 2 No specify:	Specify: Wh	+0
uraf	15 Decedent's Education (Specificantly bishopt grade completed)	16a. Decedent's Usual Occupation (Give kind of		
"nat	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	red)	
thin 7 than than edica	2	Student	Educati	ion
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exa	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica Pa Comple		Susan	Friedman	
21 d Mer d Mer s man	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or I	Rural Route Number, City or Town, Stat	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at lone. To Be Computed by Europeal Disorter	Alan Paikin (father)	13 Deer Run Newar	k,Delaware 1971	L1
Heal Fiten	20a. Method of Oisposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City o	r Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr	4 Donation 5 Other Specify:	crematory or other place) wish Community 5/ Cemetery	12/10 Wilmingt	on, DE
altil	21. Signature of Funeral Service Licenses	3 Choenberg wemo	rial Chanel	
M F 2 F ::[Michilas D. Prolled	519 Phila. Pike	Wilm., De. 198	309
Physician	23a. Fart I. Enter the disease, or complications that caused the death failure. List only one cause on each line.			Approximate Interval
/Medical	Immediate Cause (Final disease a, Multiple Injuries			Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of	rf):		
	Sequentially list conditions, b			
	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	rf):		
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	rf):		
executed an and all - transit	d			
0 H H .	UNPENDED AMENDED			
D. Box 68760, the death certificate be exemply the attending physician ched for use as the burial -	IF FEMALE: 23c. If yes, outcome of preg	nancy	23d. Oate of deliver	 y
687 ertific ding	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	ncy Month	Day Year
Box e death of the attented for us	1 Yes 2 No 9 V Unknown	eath 5 Other (Specify)		
t the de ached f	Part II. Other significant conditions contributing to death but not n	osulting in the underlying cause gives in Red I	23e. Did tobacco use contribute to	the source of death?
r, P.O. B ires that the d signed by the detached the detached the by Physical	. art in State signment contained continuing to death but her	esciting in the underlying cause given in reart.	1 Yes 2 No 3 Pro	
en sig				utopsy findings available
Cords, law require has been s		-	autopsy prior to	completion of cause of
Records, The law requires ficate has been sig page 2 should be	Ď.		performed? death? 1 Yes 2 No 1 Y	es 2 No
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit endical Certification: To Be Completed by Physician/Medical Certification:	25. Was case referred to medical	26.Place of Death (Check of	only one)	
Aysic Lities of	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursin	g Home 5 Residence 6 🗸 Othe	r; Scene
of Vi	27. Manner of Death 1 Natural 5 Panding May 6, 2010	2442 1	28d. Describe how injury occurred Passenger auto auto collision	
Division rate of an or Attending and or Attending and are death. "al Director: A led in by the fu	1 Natural 5 Pending May 6, 2010	0119 hrs 1 Yes 2 ✓ No	assenger auto auto comsion	
Vis or Ai Orec Direc		ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ıral Route Number, City
Division o Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune Medical Certification:	4 Homicide determined (Specify) Major Road	d / Highway	Sharpsburg Pike at Dunker Church	Road , Sharpsburg ,
t Hos 124 h Frun etely		ge, death occurred at the time, date and place, and		
To the H within 24 To the F complete	and manner stated.	nd/or investigation, in my opinion, death occurred a	t the time, date and place, and due to th	e cause(s)
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	nth, Day, Year)
	(CUVULT)	O.C.M.E.	May 7, 2010	
_	30. Name and address of person who completed cause of death (Item	/ *		
L.	Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 212	201	
State		A		
Registra	MAY 1 1 2019 Lenna B	parkel	May Pay to a state	
DHMH 17 Rev 1/2001 OCME 2006		ÓRIGINAL	OCME	

Amend item#17,19a,Cecil Co Health Dept vd-5/13/2010

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia Pontlitz 2010 May 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days 1 🗆 M 2 🕱 F 64 Months Hours Min. 217-44-5179 Director Maryland Ĩ946 March Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Md. Montgomery Gaithersburg 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 20230 Maple Leaf Court United States 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Automobile Sales Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William George Virginia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth States / Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 5/7/10 Alexandria, Va. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Sig tur of Funeral Se ice licen e 5038, Laytonsville Box 20882 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiac Arrhythmia minutes Medical Due to (or as a consequence of): Examiner Respiratory Arrest minutes Sequentially list conditions, if cause. Enter Underlying Cause (Disease or iinjury Due to for as a consecuence of COPD vears executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes 2 12 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2 2 No 1 Yes 2 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🕱 No Hospital: 1 ☐ Inpatient 2 🏿 ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one nd title of certifie 29b. Signature 29c, License number 29d. Date signed (Month. Dav. Year) m 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) Emil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month **PATTERSON** MAE LOTTIE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL T.ANHAM 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours Min JULY 14 1941 VIRGINIA Director 68 228-56-0770 Usual Residence of Decedent show 10a State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ¥ Yes 2 □ No PRINCE GEORGE'S COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20740 6100 WESTCHESTER PARK DRIVE #702 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: BLACK 3 Widowed 4 □ Divorced If Yes, Give Specify Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT POSTAL and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BELVA BRANDON CHARLIE E. EDMONDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1457 S. STREET N.W. APT A WASHINGTON, DC 20009 DARRYL PATTERSON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY 5/17/2010 CHELTENHAM, MARYLAND J. B.JENKINS FUNERAL HOME 21. Signature of Funeral Service Lice 22. Name and Address of Facility LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician/ ocardia disease or condition resulting in death) uluno Medical Due to ras a consequence of): Examiner b Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of eause of death? 24a Was an autopsy performe 2 No 1 🗌 Yes funeral director, Be 25. Was case referred to pedical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 \square Yes 2 **N**o 1 Inpatient 2 VER/Outpatient 3 I DOA 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Rd, Lanham, mcl mD (Month, Day, 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

1 - For State Registrar	State of Maryland / Depa <i>Cei</i>	artment of He rtificate of L			ene 0 1 0	16372
1. Decedent's Name (First, Middle, Last) GERALDINE	PERRY			2. Date of Death Month MAY	Day 2010	3. Time of Death 12:23 PM
hiner 4a. Facility Name (If not institution, give street GLADYS SPELLMAN N	eet and number)	4b. City, Town, or HYATTS			4c. County of Dea	
5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry) TH CAROLINA
Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation		PIARON 9	1923 NOK	10d. Inside City Limits
MD PRINCE GEO	DRGE'S BOWIE	10f. Zip Code		10	g. Citizen of What C	1 X Yes 2 No ountry?
	·		716		USA	
15215 NOBLE WOODS 11. Marital Status 1 Never Married 2 Married 3 Now Widowed 4 Divorced	1 ☐ Yes 2 XNo	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 💢 No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12TH	College (1-4or 5+) (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work		6b. Kind of Business	s/Industry
	HOI	MEMAKER	18. Mother's Name	e (First, Middle, M	PRIVATE laiden Sumame)	
BENJAMIN HARRISON			ELIZAB	•	RRIS	
19a. Informant's Name/Relationship (Type DORIS WATSON/DGT		•			City or Town, State, MARYLAND	
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	20b. Place of Dispo cometery, crei	esition (Name of matory or other place		Date 2	0c. Location - City or	r Town, State
4 Donation 5 ☐ Other (Specify)	BALTIMO	RE CEMETE			ALTIMORE,	
21. Signature of Funeral Service Licensee	1111				MARYLAND	20785
23a. Part 1. Enter the disease, o per plica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. Do not encause on each line. CONGESTIVE HEART Due to (or as a consequence of):		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Sayuantially list conditions b.	RESPIRATORY FAIL	JRE				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of): HYPERTENSION					
that initiated events resulting in death) Last	Due to (or as a consequence of):					
E FEMALE:		Ectopic pregnancy Other (specify)			23d. Date of de Month	alivery Day Year
Part II. Other significant conditions contr	ibuting to death but not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknown
Completed				24a. Was an autopsy perform	24b. Were a prior to death? \(\foldsymbol{\pi}\) No \(1 \subsection \text{Ye}\)	utopsy findings available completion of cause of s 2 3 No
25. Was case referred to medical examiner?	spital:	Othe	or	th (Check only one)	
Yes 2XNo	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury	ACXInursing Ho	ome 5 ☐ Resider 28d. Describe hov	nce 6 □Other (Sp. w injury occurred	əcify)
27. Manner of Death 1 Natural 2 Accident investigation 3 Suicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	Bural Route Number,
23a Cartifier 112 Certifying Physic	itan: To the basis of my knowledge, decl ir: On the basis of examination and/or in and manner stated.					
29b. Signature and title of certifier	1 12 7	29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
Leter M	Ms MD		6024		MAY 9, 20	10
30. Name and address of person who com LESTER MILES M.D.	pieted cause of death (item 23a) (Type, 1160 VARNUM STRE)		ASHINGTON	,DC 2001	7	
State 31. Date filed (Month, Day, Year) strar MAY 1 2 2010	32. Registrar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Jok. Ensure Alk Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 Year Carl Don Powley 6 10:20 ₽ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2932 Lakesville Road Church Creek Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Months Hours Min. Dec. 18 ^{Year}1942 218-40-5086 Mary Land 67 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified MD Church Creek Dorchester 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2932 Lakesville Road 23a 21622 items 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: white "natural" Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatical waterman seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Carlton O'Neill Powley Rosa Mae Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy MacLauchlan sister 5426 Cannon Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5/7/10 Delmar, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Rome P. A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy performed? prior to completion of cause of 1 ☐ Yes 2 ☐ No **To the Funeral Director;** After this certific: completed filled in by the funeral director, _I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X** No Other: မ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 1 Inpatient 2 I 5 Residence 6 Other (Specify, 27. Manner of Death

1 Natural
2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 ☐ Acciden 3 ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician /Medical 8 2:42 A MARIE 2010 Terial an 4c. County of Death lity Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 1 , 2010 5. Social Security Number 6. Sex '. Age (In yrs. last birthday) Birthplace (State or Foreign Country), **Funeral** 1 □ M 2 🕻 F Maryland Director None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 28a-f show 1 Yes 2 No Funeral Director hering ton Maryland Maizy's 10g. Citizen of What Country? ŏ items 23a 46/04 20653 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: ģ Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic content." N/A Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lekuarins ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) exists TAIL MU

20c. Location - City or Town, State 171) 20653 Jurdan /wother 46104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗷 Burial 2 🗌 Cremation 3 ☐ Removal from State Leonartown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furer Name and Address of Facility 20608 tunen Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest proximate ease, or complication Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** homis /Medical Due (of as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to for as a consequence of The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months?
1 Yes No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ PNO 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2 No 1 Yes **Division of Vital** 26. Place of Death Check onl one) or Attending Physician: 25. Was case referred to medical was case examiner? Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To after death.

Director: After this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Miscoll olleen Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year Josephine Ray May 5, 2010 11:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 980 Ponds Wood Road Huntingtown Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Director 95 212-32-7051 April 16, 1915 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at the Medical Examiner must be notified Director 1 ☐ Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a 20639 980 Ponds Wood Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify δ 3 XWidowed 4 ☐ Divorced Black Maryland 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Manager Apartment Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John Harvey ٩ Emma Hoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>0</u> of Health Linda Lee Ray-Smith - daughter Important: If Item 27 any injury or other tr once. P.O. Box 264, Huntingtown, MD 20639 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery | May 12, 2010 | Sunderland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 € No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 Yes 2-1NO 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After 1-Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5 NO

DHMH 17 Rev 1/2001

State

Registrar

Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonath an
31. Date filed (Month, Day, Year)

MAY 11 2010

owenthal.

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9100PM Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Prince George's 1111 Lindsay Rd Oxon Hill 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Country) DC 77 Director 224-40-7479 21 Sept 193 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Prince George's MD Oxon Hill 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20745 1111 Lindsay Rd U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide 2th Private or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Thomas Jones Amanda Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important; If item 27 is any injury or other trau 20745 Gregory Verrett - Son 1111 Lindsay Rd Oxon Hill MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Comfort 20a. Method of Disposition 20c. Location - City or Town, State Date 12 May 2010 1 XBurial 2 Cremation 3 Removal from State Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of FacilityMcLaughlin Funeral Home 2019 MLK Jr Ave SE Washington DC 20020 Signature of Juneral Service Licenses Part 1. Inter the disea or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failu e. List only one cause on ach line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 DResidence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of nours after death.

neral Director: After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2. 29b. Signatur nd address of person who completed cause

Registrar DHMH 17 Rev 7/2009

State

P.O. Box 68760

Division of Vital

GER

Physician/ Medical **Examiner**

Funeral Director

To Be Completed by Funeral Director

		ype or Pri						-		() 7)	h I	6378		
For State Registrar		State of Ma	aryland /			of Healt of Deatl		ientai Hy	gien Reg. N		U	0070		
	e (First, Middle, Last)							2. Date of De			3. Ti	me of Death ø		
Peggy	Ann	Sautter						Month MA 4	D	ay Year	0 2	0-18 M.		
4a. Facility Name (if	not institution, give str	eet and number)	-		4b. City, Tov	wn, or Location	on of Death		4	c. County of Dea	ath	,,,-		
Peninsula	· legion	1 medica	1/10	10	5	21/56	(///			Nicon	in			
5. Social Security Nu		7. Age	(In yrs. last b	irthday)		Year If Und		8. Date of Bir				tate or Foreign		
217-36-2 Usual Residence of	.400	M 2 X F 6	9	Yrs.	MONTHS	ays Hour	5 IVIIII.	(Month, Da 05/20/	1940) Mar	vlanc			
10a. State	10b. County		10c. City, To	wn or Loc	ation						10d. Insi	de City Limits		
Maryland	Wicomico		Frui	tland	Si					-	1 🛚	Yes 2 🗆 No		
717 S. C	_{lam} den Ave.	•			10f. Zip Co 218	^{ode} 826			10g. C	itizen of What C USA	ountry?			
11. Marital Status												ace - American Indian,		
1 Never Marri	ed 2 Married	Armed Forces? 1 Yes 2 X	No	1 _				nican, etc.)			, White, etc.			
3 D Widowed	4 🖾 Divorced	If Yes, Give Year or Dates.		'	∟ Yes 2 €	No Spec	ary:			Specify: W	hite			
(Spe	15. Decedent's Educ cify only highest grade		16	(Give ki	ent's Usual O nd of work d	lone during m	ost of worki	ing	16b.	Kind of Business	Industry			
Elementary/Seco	onday (0-12)	College (1-4 or 5			NOT use rea				1	nospital	_			
	First, Middle, Last) Aden Owens					18. M		e (First, Middle, Rebecc	Maider	Surname)				
	me/Relationship (Type		19	9b. Mailing	Address (St	treet and Nur	nber or Rura	l Route Numbe	er, City o	or Town, State, Z	ip Code)			
20a. Method of Disp			001- 01	of Disease	:t: /h/= /	-4	1					to.		
1 🖪 Burial 2	☐ Cremation 3 ☐ Re 5 ☐ Other (Specify)	emoval from State	Wico Par	mies K	Memor	1' 41 '	į) 2010		Location - City o		ile		
2) Signature of Fur	neral Service Licensee	Jamasa	⇒cFs	e 338	Name and A ST SNO	ddress of Fa W Hill	ra.,	ome Pro Salisb	fess ury	;innalı	SSOC:	lation		
23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)		ations that caused cause on each line	OPA		the mode of	f dying, such	as cardiac c	or respiratory ar	rest,		Interva Onset	ximate al Between and Death		
Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying	Due to (or as a	consequence	e of):										
that initiated events resulting in death) L	C.	Due to (or as a	consequence	e of):										
,	L													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									elivery Day	Year				
Part II. Other signif	icant conditions cont	ributing to death b	ut not resulting	g in the un	derlying cau	se given in P	art I.			use contribute t		of death?		
- Se	داً(م							24a. Was auto		24b. Were a prior to death?	completio	ings available of cause of		
- Pne	ninomin							1 ∐ Yes	2 X N		s 2 N	0		
25. Was case referred examiner?	4	spital: 🗸				Other:								
1 ☐ Yes 2 ☐ 27. Manner of Death	NO	1 A Inpatie 28a. Date of injui (Month, Day	ent 2 ER/0 y 28b ; Year)	Outpatient Time of injury	28c.	Injury at work?		me 5 Resi 28d. Describe I		6 Other (Spe	cify)			
2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inju	ry - At home, . (Specify)	farm, stree	M et, factory, of	1 Yes 2		28f. Location (mber or Rural Route Number,			

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HOUS619

St. SAlisbury Md

29d. Date signed (Month, Day, Year)

State Registrar

Medical Certificate: To Be Completed by Physician/Medical Examiner

29a, Certifier (Check only one

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A. Coker Do 100e. CARNOLL 31. Date filed (Month, Day, Year)

32. Registrar's Signature MAY 1 2 2010 back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Comico **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖬 F Min. Months Maryland Hours 1072071949 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 315 Naylor Street 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Laborer Poultry Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Edward Smith, Sr. Lula Mae Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orlando Harrison Smack/ Husband 25707 Elzey Brown Loop - Mardela Springs, MD 21837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Eastern Shore VA Cemetery 05/18/2010 Hurlock, MD Signatur of Funeral Service Licenses 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pelastalu disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 5 Other (specify) signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2. performed 1 Yes P No Yes 2 No 25. Was case referred to medica B 26. Place of Death (Check only one) examiner? 1 ☐ Yes 🖫 No Hospital Other: 뎯 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 11/10 D 63199.

State
Registrar

DGESH

address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN

910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hal F. Year Stanley 1440 M 2010 au /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rehabilitation & Nursing Social Security Number Salisburu Wicomico If Under 1 Year | If Under 24 Hrs... Birthplace (State or Foreign Country) Sex 1**X** M 2□ F 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 249-42-1993 78 Director 09/05/1931 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Essentment must be notified at 10d. Inside City Limits Director 1 AYes 2 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Williams Ave. 21826 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No white Specify Army Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver Cloverland Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Stanley Fancy Jordan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessalene Stanley/spouse 116 Williams Ave., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetety, crematory or other place Wicomico Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Handwaddener H 501 Snow Hill Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CA lan disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner gear Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> icate has been si , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed' Division of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 2 HO r this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. n 24 hours after death. e Funeral Director: A letely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the I within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3

State Registrar William H.

31. Date filed (Month, Day, Year)

MAY 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony A. Samps	ار	l- For State Registrar		e of Maryla		epartm Certifica			and	Menta			Reg. N	20		1638
Physician Medical Examine	er		hony A.	Sampso								Date of De Month May 17,	Da	y Year)		3. Time of Death 1700 hrs
		4a. Facility Name Dorchester	(if not institution, of General Hos		umber)		4	o. City, Tov Cambri		ocation of	Death			4c. County of Dorcheste		
Funeral Director		5. Social Security 218-90	-060	Sex M 2 F	7. Age (In 4	yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of 6	^{Вікн} (м	м/DD/YYYY) -1963	9. Birt Cou Ma:	hplace (State or Foreig Intry) ryland
any		Usual Residence o	of Decedent 10b. County		10c.	. City, Town	or Locatio	n								10d. Inside City Limits
≥ .		Md 10e. Street and Nu	Dorch	nester		Hui	rloc	k 10f. Zip Co	ado.				100.0	Citizen of What		1 Yes 2 No
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72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once lotted by Ernotesal Directors	runeral	11. Marital Status 1 Never Marr	ied 2 Marri	12. Was Dec Armed For 1 Yes	cedent Ever orces? 2	r in U.S.	If Ye	s, specify (Cuban, I	Mexican, F		ify Yes or Noan, etc.)	No-	14. Race - White,		can Indian, Black,
urs after tural", aminer	<u>-</u>	3 Widowed 15. Decedent's E		ed If Yes, Give Yea or Dates: only highest grad		ed) 16a. [Yes 2 🔏			nd of wor	k done	16b	Specify: b. Kind of Busin		ack
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mustel Hygiene Anne 11. If them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once TO Be Commission by Eringeral Director		Elementary/Sec	ondary (0-12)	College (1				st of workin mhan		OO NOT us	e retired)	W	illiam Farms		arper
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2 st-ould h and Me 27 is ma matic ev	2	19a. Informant's N	ame/Relationship		ther	11.5	. Mailing . 621	Address (5 Mi	Street a	and Numb	er or Rur 【ill	al Route No . Rd .	umber,	City or Town,	State,	Zip Code) Md.21643
BAITIMORE, MLD bermit. Pages 1 and 2 sty. Department of Health and important: If item 27 is njury or other traumati		20a. Method of Dis	sposition	•		20b. Place o		on (Name		etery,	C	ate	200	c. Location - C	ity or 7	Town, State
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Physician Medical xaminer	1	Immediate Cause	nly one cause on (Final disease	each line.		throm				uch as car	diac or re	spiratory a	rrest, s	shock, or heart		Approximate Interval Between Onset and Death
-	1	or condition resulti Sequentially list co		Due to (or as a	•	nce of): is thr	ombo	ses								
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by the tached f		Part II. Other signi		9 Unkno		not resulting	in the un	derlying ca	use give	en in Part		23e. Did	tobacc	o use contribu	te to th	ne cause of death?
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hysician: The larthis certificate hard director, page 2	3 2	5. Was case reference examiner?		Hospital: 1	patient 2	2 ✓ ER/Ou	toatient			Death (Cl	neck only lursing H		Poeir	dence 6 (Other:	
After this funeral di		1 ✓ Yes 7. Manner of Deat 1 X Natural		28a. Date			ime of Inju	iry 28c.	Injury a	at Work?	28			njury occurred	Julei.	
In or Attending Physician: The law requires that the state death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by Partification:		2 Accident	5 Pending Investiga	28e Place	of Injury -	At home, far	m. street	- 2 - 2 - 2		ding etc	120	Location	(Street	and Number of	r Dur	al Route Number, City
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hourst death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex			Certifying Physi Medical Examin		f examinati											
_____	2	9b. Signature and	title of certifier	200					.C.M.					Date signed by 18, 2010		h, Day, Year)
	3	0. Name and addr	ess of person who	completed caus	e of death ((Item 23a)			.0.101.	<u> </u>			IVIE	ay 10, 2010		
		Carol Allan,		ant Medical B				reet, Bal	timore	e, MD 2	1201					
State Registra	e s r	1. Date filed (Mont	"MAY"21	2010 32. Reg	trar's Sig	nature A.	400	ule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May_5, Physician/ Thomas Scherer, Sr. 2010 а м 8:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George 5. Social Security Number 6. Sex 1 □**X**M 2 □ F Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Sept. 20. 9. Birthplace (State or Foreign **Funeral** 1943 New York Months Year 067-34-7608 **Director** 66 Sept Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 7352 Gabriel Drive 20616 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Year or Dates. 1962-Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced 1983 White permit. Page 1 and 2 should be filed within 72 hour postartent of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Radioman U.S. Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John J. Scherer Claire Goetchius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Scherer Wife 7352 Gabriel Dr., Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place May 11, 20a. Method of Disposition 20c. Location - City or Town, State 2010 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 Box 573, Indian Head, 23a. Part 1. Enter the shock, or heart disease, or complications that ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between failure.List only one cause Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or iinjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No Yes Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Division of Vital funeral director. examiner? Hospital 2 00 Other: မ 1 🗌 Yes 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Accident
2 Accident
3 Suicide
4 Homicide 5 Pending 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Funeral Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

10-03516 Sarah Ann Swann

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (i	if not institution			mber)			. City, To Newbu	own, or Lo	ocation of		, , ,	4c	County o	f Death	
Funeral		5. Social Security N		6. Sex		7. Age (In yrs. I	ast birthday)	┺	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth (MM/	DD/YYYY	9. Birt	hplace (State or Foreign
Director		579-26-9		1 M	2K F	85	• • • • • • • • • • • • • • • • • • • •	rs.	Months		Hours	Min	Apri1	,		Cou	virginia
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1215-0036 be filed within 7 antal Hygiene. rrked other than	Be	Earl Mal	loy I	ishba							Mary	Wi	ne				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	բ	19a. Informant's Na Charles (dson		_		•			al Route Nu and , M		ty or Town 0625	, State,	Zip Code)
re, N s 1 and f Health If item er trau		20a. Method of Dis 1 X Burial 2		3 D B	Removal fro		Place of Disp crematory or	ositio	on (Name				Date	_	ocation -	City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hes important: If ite injury or other tr		4 Donation 5	Other S	pecify:	tomovar no	Mar								_		ham	,Maryland
Bal permi Depar Impo injury	1	N.17	Signature of Funeral Service Licensee M01458 22. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A. 20646 a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart Approximate I													46	
Physician		failure. List only one cause on each line.													Approximate Interval Between Onset and		
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an: T ertifica stor, pa	Be	25. Was case refer	red to medica						26	6.Place of		Check on!					
Vit.	To		2 No	Hospi	' "	patient 2	ER/Outpatie								nce 6 🗸		Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should b.		27. Manner of Deat 1 Natural	5 Pen	ding	28a. Date of May 6, 2	of Injury Day Year) 010	28b. Time o 1124 hrs	f Inju		c. Injury a		Pa	id. Describe Issenger				ollision
visic or Atte fter des Directo in by tl	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) RT. 301 & Rt. 234, Newburg, MD															
Di spital cours a filled	Cert	4 Homicide	dete	rmined	(Specify)	Major Road	d / Highwa	ау				RT	. 301 & Rt	. 234, N	lewburg,	MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	29a. Certifier 1 (Check only one) 2		miner:On	the basis o	of my knowledg f examination a											
To Mij	Me	29b. Signature and	title of certific		manner st	ate0.			29c.	License n	number	-		29d. D	ate signe	d (Mon	th, Day,Year)
		Panel	u Du	Hall	MD	1				O.C.M.	E.			May	7, 2010)	
BB 15		30. Name and edd: Pamela E. S				e of death (Item Medical Exa	-	11	Penn S	Street, l	Baltimo	re, MD	21201				
Si Regis	tate trar	31. Date filed (Appr	1121)	2010	100	gistrar's Signat	re San	K	1								
	-				<u> </u>		A 12 A 1	-									

DHMH 17 Rev 1/2001 OCME 2006

OCME

			For State Registrar	State of M	aryland / Dep <i>Ce</i>			lealth and M <i>Death</i>	1ental Hy	/giene Reg. No.	2010	638	
	Physici	an	Decedent's Name (First, Middle, La.	st)		-			2. Date of D Month		Year	3. Time of Death	
0	/Media		Esther Sutto			1			May	- 6	2010	6:13 PM	
	Examir	er	4a. Facility Name (If not institution, giv			4b. Cii		r Location of Death	•		County of Death		
and the same			Sinai Hospital of 5. Social Security Number 6. S	ex 7. Ac	e (In yrs. last birthday	/) If Unc	ler 1 Year	If Under 24 Hrs.	8. Date of B	Į.			
	Funeral Director		245-72-7217 19 19 19 19 19 19 19 19 19 19 19 19 19	□ M 2□F	94 Yrs.	Month	s Days	Hours Min.	8. Date of Bi (Month, D 5 / 26 /	1 9 1 5	Nort	place (State or Foreig intry) hCarolin	
	land ow		10a. State 10b. County		10c. City, Town or L	ocation	-					10d. Inside City Limits	
	Mary Frsh	tor	MD Baltim	ore	Balt:	imor	е					1 🔀 Yes 2 🗌 No	
	r 28a	Director	10e. Street and Number		1	10f. 2	Zip Code				zen of What Cou	intry?	
	h witl	al D	2513 Oswego A	venue			212	15		τ	JSA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examinate rount be rediffed at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13		cedent of Forecify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		4. Race - Amer Black, White, Specify: Bla	etc.	
Õ	2 hou	ted	15. Decedent's Ed	ucation	16a. Dec	edent's U	sual Occur	pation		16b. Kir	nd of Business/I	ndustry	
215	hin 7	Completed	(Specify only highest gra	de completed) College (1-4or l	5+) (Giv life.	e kind of V DO NOT	vork done use retire	during most of work d)	ing			. ,	
	d wit	Son	6		Hou	seke	eper			Hos	spitali	Lty	
land	ıld be file fental H) rked oth iic event	To Be (17. Father's Name (First, Middle, Last, Frank William					18. Mother's Name Ada P			Surname)		
Maryland	nd 2 shou aith and N 27 Is mai r trauma		19a. Informant's Name/Relationship (Virdy Wilkes	Type. Print)				and Number or Run				ip Code) 21215	
nore,	ages 1 an nt of Hea t: If item / or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Disposer cemetery, cri	position (Nematory o	lame of r other place	ce) ty 5/13	Date / 2010	1	cation - City or T		
Baltimore,	permit. P. Departme Important any Injury once.		4 Donation 5 ☐ Other (Specification 21. Shrutum of Funeral Service Licer	and the same of the same		22. Name	and Addre	ss of Facility S	Conno	or Me	emoria.	l Funeral NC 28580	
	O		Punus	17.1		ome					11111		
	Physician /Medical Examiner		23a. Par 1. Enter the circease, or com shock, or heart fail re. List only Immediate Cause (Fina disease or condition resulting in death)	one cause on each li	the death. Do not e	of	10	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
		niner	Sequentially list conditions, if any, leading to immediate cause. Et let Underly! Cause (Disease or injury that initiated events	bDue to (or as	a consequence of):								
,0928	ficate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):								
w.	tificat g phy as the	edic								- 1			
O. Box	the derthicertific / the citerring pi ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		2 Fetal death 3		c pregnanc (<i>sp</i> ec <i>ify</i>) _	ру		2	23d. Date of deli Month	very D <i>a</i> y Year	
О.	requires that the een signed by th nould be detache	된	Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying	g cause giv	ven in Part I.	23e. Did	I tobacco u	se contribute to	the cause of death?	
ds	sign d be	d by	Hyperte	nsian					1 🗆]Yes 2[□No 3□Pro	obably 4 🗆 Unknowr	
Records,	elaw hasb ie2st	Completed							24a. Wa	s an opsy formed?	24b. Were aut	topsy findings available ompletion of cause of	
<u></u>	dcian; The certificate h ector, page								1 □ Yes	2 □ No	1 ☐ Yes	2 □ No	
of Vital		Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat					
of	Phys	유	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpati	ent 2 ER/Outpati		DUA	4 🗀 Nursing Ho	me 5 Res 28d. Describe		- , ,	eify)	
	ing Affer une	ion	1 Natural 5 ☐ Pending	(Month, Da	ay, Year) Injury	M	28c. Inju Wor	k? Yes 2 □ No	Zou. Describe	s now mjur	y occurred		
Division	or Attending after death. Director; Afte in by the fune	Certification: To	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		jury - At home, farm, s tc. <i>(Specify)</i>				28f. Location City or To	(Street and own, State)	d Number or Ru)	ral Route Number,	
_	ne Hospital or Attend 124 hours after death ne Funeral Director; /	Medical Ce			of my knowledge, dea of examination and/or								
	To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifier	and manner s	aucu.	- 1	29c. Licens	se number		29d. Date signed (Month, Day, Year)		ı, Day, Year)	
	F ≥ F 0				-			_	nber 29d. Date signed (Month, Day, Year)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Chad J. Hansen, M.D. 31. Date filed (Month, Day, Year) MAY 13

2401 W

M.O.

21215 MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D59062

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 Physician/ Month May Dorothy Leviathan Sweeney 9 6:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 285 Main Street Anne Arundel Lothian 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 🖾 F Months Days Hours Min. 578-16-6292 89 Avenue, MD 920 Director Aug Usual Residence of Decedent If lied within 72 nours when the Hygiene.
ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 285 Main Street 20711 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.
White \$ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit, Page 1 and 2 should be filed wit Department of Health and Mental Hygiel Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Alton Frederick Cheseldine Ida Blanch Waltemeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel C. Sweeney (husband) 285 Main Street Lothian, MD 20711 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 🛛 Cremation 3 D Removal from State May 11,2010 Clinton, MD Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert 21. Signature Juneral Service Licensee Cary J. Goff 8125 Southern Maryland Blvd. Owings, MĎ 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EVERE PERIPHERAL NEUROPATH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MELLITUS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Year 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIJEASC CORONARY ALTERY Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending ☐ Accident ☐ Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP. RD. PR, FREDERICK 20678 ANWAR MUNSHI MD Sinle 300 130 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

DHMH 17 Rev 7/2009

			for State Registrar	State of M	laryland	rtment of F tificate of t		d Mental F	lygien Reg. N	- 2 N I N	638		
	Physici		1. Decedent's Name <i>(First, Midd</i> Edna	lle, Last) May		S	Soulsby		2. Date of Month Apri	D	ay Year 2010	3. Time of Death 4:20 A	
And the second	/Medio		4a. Facility Name (If not institution Golden Living		r)		4b. City, Town, or Cumb	Location of Deerland			c. County of Death		
	Funeral Director		5. Social Security Number 214-07-3160	6. Sex 1 □ M 2 😾 F	nge <i>(In yrs. la</i> 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours M	lin. (Month,	Birth Day, Year	r) Cou	pplace <i>(State or Foreign</i> intry) ryland	
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD A	llegany	10c. City,	Town or Loc	umberlan					10d. Inside City Limits	
	h with the N 23a or 28a-	Funeral Director	10e. Street and Number	nia Avenue			10f. Zip Code	21502	2	10g. C	Litizen of What Cou	intry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Experiment until be inclined at ance.	þ	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	If Yes, Give 4	? }No	1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2☐ No	ispanic Origin an, Mexican, Pu Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify:		
21215-0036	within 72 hor iene. than "natur.	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired memaker	during most of	working	16b.	Kind of Business/Ir		
and 2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, It also	Be	17. Father's Name (First, Middle William	, Last) Arthu	ı p		isner	_	Name (First, Mid	dle, Maide		1.	
Maryland	d 2 should th and Me 7 Is mark traumati	10	19a. Informant's Name/Relation James C. Souls	ship (Type. Print)	41	19b. Mailin	g Address (Street		r Rural Route Nu		or Town, State, Zi		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)	3 ☐ Removal from State	e ce	ace of Dispo metery, cren	winire sition (Name of natory or other place [emorial	e)	Date	20c.	MD 215 Location - City or T Lumberlan	own, State	
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service	Licensee		22	Name and Addre	ss of Facility	Adams F	amily	Funeral	Home, P.A 21502	
	Physician /Medical Examiner		23a. Part1 Scher the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	y arrest,		Approximate Interval Between Onset and Death							
68760,	ficate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	s a conseque								
O. Box 68	the death certific the attending p ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у		_	23d. Date of deliv	very Day Year	
rds, P.	puires that n signed by	þ	Part II. Other significant condit	ions contributing to death	but not resul	Iting in the ur	nderlying cause giv	en in Part I.		id tobacco	14	the cause of death?	
of Vital Records,	The law rec ate has bee page 2 shou	Completed	0!	35					24a. W a p 1 □ Ye	utopsy erformed?	prior to co	topsy findings available ompletion of cause of 2 □ No	
f Vita	hysician: his certific	To Be (25. Was case referred to medical examiner? 1 ☐ Yes No	Hospital:	tient 2 □ E	ER/Outpatien	t 3 DOA Oth		Death <i>(Check on</i> ng Home 5 ☐ R		6 □Other (Spec	ify)	
Division o	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	27. Manner of Death Tall Natural Call Accident Call Could Call Homicide Toward Call Could Could Call Could Call Could	igation not be prined 28e. Place of I	Day, Year)	28b. Time of Injury me, farm, stre	M 28c. Injur Worl 1 1 eet, factory, office	y at ⟨? Yes 2 □ No	28f. Locatio	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route City or Town, State)			
	e Hospita 24 hours ie Funeral bletely fille	Medical C	29a. Certifier (Check only one) 1 Certifyi 2 Medica	ing Physician: To the besing Examiner: On the basis and manner:	of examinati	vledge, deatli ion and/or in	n occurred at the tile vestigation, in my co	me, date and popinion, death of	lace, and due to occurred at the tire	the cause ne, date a	e(s) and manner as and place, and due	stated. to the cause(s)	
	と で で withii で の mg	Me	29b. Signature and title of certific	dur	M	1	29c. Licens	e number Y98	/	29d. D	Date signed (Month	, Day, Year)	
	30		30. Name and address of person	HACMOS, 1	death (Item	23a) (Type,	engton	Cornel	, Cum	beil	and, Md	21502	
	Sta Registr		31. Date filed (Month, Day, Year MAY ()	3 2010 Ine	strar's Signati	g. S.	arked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 3, 2010 **Physician** Martin Lewis Sarns 5:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing & Rehab. Center Prince George's Hyattsville 8. Date of Birth (Month, Day, April 5, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 10 xM 2 □ F 217-66-1864 56 1954 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ∏Yes 2 XINo Director Maryland Prince George's Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 905 Glacier Avenue 20743 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc. XX Yes 2 ☐ If Yes, Give Year or Dates: , or i 1 ☐ Never Married 2X Married Maryland 21215-0036 1 □Yes 2NX No ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Record Store 2 years Management is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Isadore Samkofsky Mary Carolyn Lineburg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine F. Sarns / Wife 905 Glacier Avenue Capitol Heights, Maryland If Item 27 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 P Department of Important: If it any injury or c XX Burial 2 Cremation 3 Removal from State Resurrection Cemetery 5/13/2010 Clinton, MD 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur of Hun / I Service Licensee any ir 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FILS disease or condition /Medical resulting in death) Examiner vermoni 4 welks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed Due to (or as a consequence of): burial-1 Box 68760. physician Physician/Medical law requires that the death certificate the as attending IF FEMALE nse s If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown ρ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 s page certificate 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending thours after death.

uneral Director: Afely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours after

To the Funeral Direct

completely filled in by Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queenshow, Rol Hyattsv. NEMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pr			ndelible Inloartment of H		•		Legible.				
	•	For State Registrar		State of N	naryian	•	ertificate of L			giene Reg. No.	2016	5338			
Physicia Medic		1. Dec ed ent's Name	e (First, Middle, ENE	Last)	SCA	RLETT			2. Date of Dea Month MAY		2010 Year	3. Time of Death 7:30 A M			
Examin	er	-		give street and number) ART STREET				r Location of Death			County of Deat RINCE G				
Funeral Director		5. Social Security No. 577-62-4		6. Sex 1 □ M 2 □ XF 7. A	ge (In yrs. I	as <i>t birthday)</i> 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th ^{y,} 1°9 ′4∠	9. Birt WASI	hplace (State or Foreign			
and show t at	or	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits			
or 28a-f notified	Funeral Director	MD 10e. Street and Nun		E GEORGE'S	S	PRING	DALE 1 10f, Zip Code			10a Citi:	zen of What Co	1 🏋 Yes 2 □ No			
s 23a o	neral	9007 HOB		REET			20774	'	1	USA	zeri di vvilat co	unity:			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ed 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	4. Race - Amer Black, White Specify: BL				
72 hou n "natu Aedical	Completed			t grade completed)		(Give	edent's Usual Occup kind of work done of OO NOT use retired)	during most of wor	king	16b. Kir	nd of Business I	Industry			
d within ygiene. her tha	Be Cor		2TH	College (1-4 or	5+)	1	nistrativ	e Assista			/ERNMEN	Γ			
d be filed Mental H arked ot atic even	To B	17. Father's Name (i	First, Middle, La	•	-			18. Mother's Nan BESSIE		Maiden S	urname)				
nd 2 shoul ealth and I m 27 is m			SCARLE	ip (Type, Print) ETT/HUSBAND		9007	ing Address (Street and HOBART Street and Hobart		PRING D		own, State, Zip • MARYL	AND 20774			
Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disp 1 🔀 Burial 2 4 🗆 Donation	cation - City or LAND , M.												
permit. Depart Import any inj		21. Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785													
Physician/ Medical Examiner)r	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ENDOMETRIAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to humediate cause. Enter Underlying													
cate be executed physician and s the burial-transit	edical Examiner	d dry, feating to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying linjury s	c. Due to (or as											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ∑ 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 D Feta at time of o	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	sy		2	3d. Date of deli Month	ivery Day Year			
quires that then signed by uld be deta	ğ	Part II. Other signif	ficant condition	ns contributing to death	but not res	ulting in the	underlying cause giv	ven in Part I.		_		the cause of death?			
The law rec cate has bee ; page 2 sho	Completed								24a. Was a autop perfor	osy rmed?	prior to death?	opsy findings available ompletion of cause of 2 🔯 No			
ysician s certifi director	To Be	25. Was case referred examiner? 1 Yes 2 2		Hospital:	tient 2 🗆	ER/Outpatie	26. Pl	ace of Death (Checer:	k only one) ome 5 🔽 Resid	lanca 6	Other (Speci	ful			
nding Phy ath. r; After thi e funeral		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	h 5 □ Pending Investiga	28a. Date of in (Month, D	ury	28b. Time of injury	of 28c. Injun	y at	28d. Describe h						
tal or Atte rrs after de al Directo red in by th	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determir	28e. Place of Ir	jury - At ho tc. <i>(Specify</i>		reet, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,			
ne Hospi n 24 hou ne Funer pleted fill	Medical	(Check 2	Medical Ex	Physician: To the best on caminer: On the basis of Nurse Practioner: To the	examination	n and/or inve	stigation, in my opinio	on, death occurred a	it the time, date a	nd place, a	and due to the c	ause(s) and manner stated.			
To the within To the com		29b. Signature and	title of certifier) our	0		29c. License	number 142		29 d. Date MAY	signed (Month	, Day, Ye <i>ar</i>))10			
26				rho completed cause of M.D. 10301		, , , , ,	*	VER SPRII	NG,MARYL	AND	20902				
Stat Registra		31. Date filed (Monti				facts									

Funeral 11

<u>8</u>

Completed

Be (

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Examine

Physician/Medical

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Completed

Be

Medical Certification: To

should be filed within 72 hours after death with the Maryland

Pages 1 and 2 s ment of Health ar

Physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

funeral director, page 2 should

filled in by

Box 68760.

P.0.

Division of Vital Records,

/Medical **Examiner**

burial-trar

Baltimore, Maryland 21215-0036

For		State o	f Ma	ryland /	Depa	irtment o	f Healt	ygie	ene	10	165	389		
State Registrar					Cer	tificate d	of Dear	th		Reg	J. No.	: 0		
Decedent's Name	e (First, Middle	Last)							2. Date of D	eath	Day	Year	3. Time of	Death
Francis	Edward	Scott							May 1	1,	2010	rear	8:10	АМ
. Facility Name (/	f not institution,	give street and nu	mber)			4b. City, Tow	n, or Locati	on of Death			4c. County	of Death	1	
Riderwoo	Riderwood Village							Spring	5		Mon	tgom	ery	
Social Security N 506-34-8	oirthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of B (Month, D October)av.)	^(ear) 1932	Cot	nplace (State of untry) ha, NE	or Foreigr				
sual Residence of				10 01 T								1	40-Lineida O	14 I I IA
a. State	10b. County			10c. City, To	wn or Loc	cation					10d. Inside C	ity Limits		
aryland	Montgo	mery		Silv	er S	Spring							1 X Yes	2 □ No
e. Street and Nur	nber					10f. Zip Cod	le			100	. Citizen of	untry?		
3160 Gra	acefiel	d Road					20904				USA			
Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: KOREAN						Vas Decedent fYes, specify (☐Yes 2🏋	Suban, Mex	ican, Puerto	pecify Yes or N Rican, etc.)	0-		ck, White	rican Indian, , etc. ite	
(Specify only highest grade completed) I (G						lent's Usual Oo kind of work do	king	16b. Kind of Business/Industry			ndustry			
Flementary/Secondary (0-12) College (1-4or 5+)						Gonsultant Mitch						L1 B1	coadcas	ting

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print)

John Albert Schuchart

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mildred Kessler

Wendy S. DeLapp / Daughter 20a. Method of Disposition

20503 Ivory Pass Court, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee

5/12/2010 Metropolitan Crematory 22. Name and Address of Facility

Alexandria, Virginia 4739 Baltimore Avenue

Immediate Cause (Final disease or condition resulting in death)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a conseque	ence of):
Comphys 1 Vage	aular Artor

Arteriosclerotic Disease Vascular

Due to (or as a consequence of)

Advanced Dementia

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

Ye ar

Assisted Living

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient

24a. Was an 2 🖾 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 26. Place of Death (Check only one) 1 □Yes 2 🗆 No

1 ☐ Yes 2 🔀 No 27. Manner of Death

1 X Natural 2 Accident 6 Could not be determined 3 Sulcide 4 ☐ Homicide

31. Date filed (Month, Day,

MAY 1 2 2010

25. Was case referred to medical

Date of Injury (Month, Day, Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 🖸 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eileen K. Gemmell, 3160 Gracefield Road, Silver Spring, MD 20904

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF, G904, 6/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2046M AHI 2010 mAMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** med BUTNIE Fen 9 If Under 1 Year | If Under 24 Hrs. Social Security Numbe 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 313-86-4569 1 😿 M 2 🗆 F Months Davs Hours Month, Day, NOV 6 SIERRA 55 1954 **Director** LEONE Usual Residence of Decedent f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD HOWARD COLUMBIA 14 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9005 WATCHLIGHT COURT 21045 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian 42 should be filed within 72 hours after dec 11th and Mental Hygiene. Black, White, etc à 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4YRS ENTREPRENEUR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er ALIKALIE SILLAH MEMUNAH KAMARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZAINAB SILLAH/WIFE Sainabou Suso 9005 WATCHLIGHT COURT COLUMBIA, MARYLAND 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State FREETOWNE, SIERRA LEONE 4 Donation 5 Other (Specify) LOLOYA PLOT 5/28/2010 JENKINS FUNERAL HOME J. B. Signature of Funeral Service Licenses 22. Name and Address of Facility LANDOVER ROAD LANDOVER, MARYLAND 7474 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ teriosalerotic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ertensio that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown a \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA ၉ within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No Investigation 6 Could not be Accident Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier PUT 10 Name and address of person who com cause of death (Item 23a) (Type, Print) m 1 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2010 HAY 1

DHMH 17 Rev 7/2009

Registrar

2

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year DIXM 04 940 Savoy Ann Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 1 Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □X€ (Month, Day, Year 2-10-49 S. Country) Director 248-82-8558 61 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Director 1 A Yes 2 ☐ No Prince George Oxon Hill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20745 USA 1517 Southview Dr Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Delores McCurdy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Southview Dr.Oxon Hill MD 20745 Francis D. Savoy/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 5/15/2010 Waldorf MD 4 Donation 5 Other (Specify) Hertiage Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5 20608 Home Pa, Aquasco MD Adams Funeral M01589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition naranulosa went Medical resulting in death) Examiner Gayantiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine nticoasi and that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Hospital 2 X No 1 🗌 Yes 1 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔼 Natural 5 \square Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Location (Street and Number or Rural Route Number, ģ determined hours after City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Partner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Rd. Silver 1500 Forest 7-0910 31. Date filed (Month 32. B istrar's Signature State 3 201 Registrar

Mai

Saroy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY Year 17:30 a 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Min Director r9 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director or 28a-f 1 1 Yes 2 □ No rasonv. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ö 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hiddle minportant; if item 27 is means injury or other. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Rosie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 Denton Angela Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 15/10 5 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Henry Funeral Home, P. A
SIC Washington 21. Signature of Funeral Service Licenses Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain Physician Herniation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ntracerebia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on Stroke been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 2 M No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) P23080 8, 2010

State Registrar DHMH 17 Rev 7/2009 Maryland

22

S. Greene St.

Baltimore

MD

of

University

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phelan,

MAY 12 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9 2010 Year CARMEN TURNER 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death KLINE HOSPICE HOME MT. AIRY FREDERICK 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. JUNE 6 Director 577-96-6931 45 1964 WASHINGTON, DC Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 14 Yes 2 No MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 HOLLYBERRY WAY 21703 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 X Never Married 2 Married <u>გ</u> Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other the 5+ SOCIAL WORKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WARNER W. TURNER CINDERELLA C. TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s nt of Health a : If item 27 i 1812 BENSON LANE FORESTVILLE, MARYLAND CINDERELLA C. TURNER/MOTHER 20747 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State HARMONY CEMETERY 5/15/2010 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) METASTATIC BREAST CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day the 9 🗌 Unknown ed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ☐ Yes 2 X No 1 ☐ Yes 2 💢 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 \square Pending injury work? Division 2 🗌 No 2 Accident
3 Suicide filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number

State

Box 68760

P.O.

Records,

of Vital

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

2 2010

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MI

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) =5 Kander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LETICIA BUENAVENTURA VINAS 2010 MAY 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 46-Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be retified at 1 ☐ Yes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 2 3 D Widowed 4 Divorced onio Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental ည 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Numb permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any Injury or other trau 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition 20c. 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions ner Duri to (or selections aquence of) It any leading to trained acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir requires that the death certificate be executed and Due to (or as a consequence of): burial Box 68760. physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Xivo ģ Month Year 5 Other (specify) P.O. the 9 Unknown þ signed to be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been si 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician; director, 25. Was case referred to medica Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending n 24 hours after death. Re Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature a e of certifier 5101018528 (MI) dress of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL

State Registrar SHELDEN

MC

USN

32. Registrar's Sign

STEVEN

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Month Day Physician/ 2010 JAMES 5 4:45 P WHITEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5704 Trailview Ct./ Apt - A 12 Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June II Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 ☐ F Days Hours Mary Land Director 212-24-6902 81 Yrs. 1928 June Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 5704 Trailview Ct./ Apt- A 12 21703 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Year or Dates. 1946-49 3 X Widowed 4 Divorced Completed **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aluminum Manufacture 12 Quality Control Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Whiten Gussie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Trailview Court Apt Al2 Frederick, MD 21703 Dolores Whiten/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resthaven Mem. Gards | 5/10/2010 4 Donation 5 Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA eyof Funeral Service Lic 1621 Opossumtown Pike, Frederick, MD 21702 daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e, or complications that Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea Immediate Cause (Final disease or condition Physician/ 10420 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and I-transit death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform certificate 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) eral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No hours after death. Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

Division of Vital

(Check

only one) 29b. Signature

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

de

Kauffman 300 W. Ninth Street Frederick, MD 21701

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / [Department of Heal Certificate of Dea		ental Hygie	2010	16396	
	Physici /Medi		1. Decedent's Name (First, Middle, Las	vheedletor	1	2	2. Date of Death Month	Day Year 2010	3. Time of Death <i>Q-115</i> M	
\ 	Examir Funeral		4a. Facility Name (If not institution, give Memorial Hosp, of 5. Social Security Number 6. Security Number 11	Easton 7. Age (In yrs. last bir			B. Date of Birth (Month, Day, Ye	TALBOT 9. Birthp Count	ace (State or Foreign try)	
	Director squal to the part of	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow		50	3-0-0		Od. Inside City Limits 1 ②XYes 2 □ No	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Item 27 is marked other than "natural", or Itema 23a or 28a-f show important: If Item 27 is marked other than "natural", or Itema 27 is marked other than "natural Erich in all must be notified at once.		10e. Street and Number	ster (Can	10f. Zip Code		10g.	Citizen of What Coun		
036			11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 No Spe	ic Origin? (Spec exican, Puerto Ri ecify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White,		
21215-0036	filed within 72 ho Hygiene. other then "netu ent, I've Muller!		15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation 16a de completed) 16a College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	nost of working	161	N/A	lustry	
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	1 and 2 sho Health and tem 27 Is m		19a. Informant's Name/Relationship (7) Pashia En 20a. Method of Disposition	nels 8	n. Mailing Address (Street and No. 2) Pine Single S		nbridge		11413	
Baltimore,	permit, Pages 1 and 3 Department of Health Important: If Item 27 any Injury or othar tri once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Mid-	Shore Cremuly 22. Name and Address of F	s 5/11/	2010 Ca	imbridge eral Horm	MD	
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>	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
3760,	eath certificate be executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence d						
P.O. Box 68	The law requires that the death certificate be executed ate bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ry Day Year	
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Division	ital or Attanors after death rs after death al Diractor: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	and 28e. Place of injury - At nome, farm, street, factory, office 28f. Locati			f. Location (Stree City or Town, S	ion (Street and Number or Rural Route Number, or Town, State)		
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	MG/WHZ (MS) D50094-MD 5/7							Date signed (Month, I	i ()	
	١		30. Name and address of person who of M- LANGFITT, M		(Type, Print) nnece D S	te loy	EGST	~ mo	21601	
•	Sta Registr		31. Date filed (Month, Day, Year) MAY 13 200	32 Registrar's Signature	back					

DHMH 17 Rev 1/2001

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State of Maryland	Department of Health and Mental	Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Day **Physician** WALTMAN THEL 2:40 PM MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Norsing Cumberland Allegany Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 96 1 ☐ M 200 F 217-18-4825 9-4-1913 Director Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Is marked other than "natural", or Items 23a or 28a-f ahow traumatic avent. It a MixIcal Examinating that the notified at Cumberlano 1 Yes 2 No Director ALLEGANY MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA OR EXT 21502 901 SETON Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER GAS STATION 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RITCHEY WILLIAM BELLE KENNERY BLAIR LAURA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If Item 27 le any injury or other trai once. 701 E, 4th St APT 407 Comberland MD Z150Z PORTER DGH MONNIA L. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 ■ Removal from State 5-7-2010 Comberland MD Sunset Mem. PK 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility HARVEY H. Zeigler FH INC 169 Clarence ST Hynuman PA 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Corona 10 4V) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Hospital: 1 🗌 Inpatient Other: 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 4 hours after death. Funeral Director: After ely filled in by the fur M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Acrifying Physician: To the best of my knowled e, death occurred at the time, date and place, and due to the causals, and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) as 2010 Do0 33280 ∖⊙ ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LE Kent Ave \$101 Cumberland MD 21502 Santi mota m D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Geneva S. Jarshel Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2, Physician/ 2010 1305 P Janie Mae Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎛 F Months Hours 1933 South Carolina 76 Yrs. Director June 578-42-8988 Usual Residence of Decedent or 28a-f shov 10a, State be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show 10b. County Director 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20032 United States 900 Varney Street SE # 214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: African Completed 3 Divorced 4 Divorced Americar 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ഉ Alvin B. Wright Nancy Whren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Barnes/ Daughter 203 N Street SE Apt. #31 Washington, DC 20024 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State May 2010 Washington National Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Servi 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24aaWas an autopsy death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 Νo မ 1 Tes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 28b. Time of 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Ccident Suicide Homicide 5 Pending injury work? 2 No Investigation within 24 hours after death To the Funeral Director: , completed filled in by the 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d Date signed

State

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16399 State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Shirrel Roger Young 12:47A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 CA **Funeral** 1 X M 2 □ F Months Min. (Month, Day, Year) October 28, 1945 Hours **Director** 545-60-6907 64 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD St. Mary's Mechanicsville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30026 Arbor Hills Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\square\) No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)

Human Resource Manager mit. Page 1 and 2 should be filed within 72 sartment of Health and Mental Hygiene. fortant: If item 27 is marked other than 'injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State Power Conversion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Shirrel Robinson Young Norma Rose Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Young/Wife 30026 Arbor Hills Way, Mechanicsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Maryland Veterans Cem. 5/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. AREHART-ECHOLS FUNERAL HOME, P.A. 20646 Mary's Ave Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac disease or condition minute Medical resulting in death) Examiner Due to (or as a consequence of): Hyporta Sequentially list conditions, if any leading to immediate if any leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Ision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide 1 Yes 2 🗆 No Investigation Could not be within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9th 2010 2482 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) LEONARDTOUN, BOX JAMES DAMACRUIT 31. Date filed (Month, Day, egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Regina Veronica Young Month 20ปี May 4 6:36 Medical 4a. Facility Name (if not institution, give street and number)
Washington Adventist **Examiner** c. County of Death Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. (Month, Day, | April 11 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 579-40-7179 **Funeral** 1 D M 2 1 F WashingtonDC Director 1931 Usual Residence of Decedent shov 10a. State 10b County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f s notified DC Washington, DC Yes 2 No 10f. Zip Code 20011 10e. Street and Number ö 10g. Citizen of What Country?
USA er than "natural", or items 23a or the Medical Examiner must be 22 Hawaii Ave. NE Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify Completed 3 🖵 Widowed 4 🗌 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Fed. Govt (NIH) Bio Meter Reader Be 17. Father's Name (First, Middle, Last)
Arbury Swann 18. Mother's Name (First, Middle, Maiden Surname)
Hortense Reese ೦ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20002 Tawanna Young/ Daughter 334 Adams St. NEWashington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ft cemetary frematory Prother Clace 1 Burial 2 Cremation 3 Removal from State 5-14-10 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pridgen Funeral 9013 Annapolis Rd Lanham, 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Tetastatic Physician/ disease or condition Cancer Medical resulting in death) Examiner Due to (or as a consequence of): Ow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? After this certificate has been signed by the atte funeral director, page 2 should be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No Yes 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants and the Funeral Director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 lakoma 31. Date filed (Month. Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 640 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2ď1°b 30, 11:30 AM Bassel Antoine Zelof 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Rockville Year I If Under 24 Hrs. Montgomery Hospice Casey House Montgomery

9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 DM 2 □ F 577-94-9471 44 Oct. 17, 1965 Israel Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Palmspring Dr. #7 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White std dle 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify 3 Widowed 4 Divorced Eastern 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Administrator LMS Integrity One Partner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antoine N. Zelof Virginia Delcarmen Flores 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Su Zelof/Wife 303 Palmspring Dr. #7, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Inc. 05/05/2010 Hampstead, Maryland 21. Signature of Funeral Service Licensee ²PYTETS TESSEFATY Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Osteosarcoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Exemples 1, ust be rutified at

27 Is marked other than "r, r traumatic event

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other trong once.

1 and 2 should be fill Health and Mental H tem 27 is marked ott

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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attending physician for use as the buria

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit WIL 30

lical Exami	Cause (Disease or injury that initiated events resulting in death) Last	c										
Completed by Physician/Medical Examil	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Event in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day											
ted by PI	Part II. Other significant conditions co	ntributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco		to the cause of death? Probably 4 Unknown						
Comple				24a. Was an autopsy performed? 1 □ Yes 2 ₩	prior to death	autopsy findings available o completion of cause of ? es 2 □ No						
Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)								
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Residence	6√DOther (S	pecify) Hospice						
cation: 1	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury N	28d. Describe how inj	jury occurred	nospice							
Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	28f. Location (Street a City or Town, Sta	 Location (Street and Number or Rural Route Number, City or Town, State) 								
27. Manner of Death Natural Natu												
Ž	29b. Signature and title of certifier	1	29c. License number	29d. E	Date signed (Mo	onth, Day, Year)						
	Dune Ka	ellet CARP	R115108	Ma	ay 6, 20)10						
	30. Name and address of person who co Diane Ruckert CRI	ompleted cause of death (Item 23a) (Type, Print) NP 6001 Muncaster Mil	1 Rd., Rockvil	le, MD 2085	55							
е	31. Date filed (Month, Day, Year)	32. Registrar's Signature										
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01		Old Parket										

DHMH 17 Rev 1/2001

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Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 Day Anthony Roxie 20 ได้ 1:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Overlea Health Reh Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F 83 Months Days Hours Min. (Month, Day, Country) 216-24-8147 **Director** 2-27-1926 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland aţ Director notified 28a-f 1 🗌 Yes 2 🗓 No Balto Catonsville 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 19 Pecan Street 21228 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black 3 XWidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John Wilson Francis Bullock 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Catonsville, MD 21228 19 Pecan Street Annie Hawkins Martin-20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 5-27-2010 Balto, MD Carmel Cem 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Li 22. Name and Address of Facility March East F/H BaLTO, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 1 Month Day Year Pregnant at time of death the ped Unknown g Unknov signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown No page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a, Certifier vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:10 A M 2010 Alberti Joseph May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Greater Baltimore Medical Center</u> Baltimore Towson 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Feb. 15 Mary land 219-12-5540 Director 85 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore **Baltimore** Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21239 U.S.A. 1220 St. Andrews Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 10/1 Black, White, etc. 1 Never Married 2 X Married Completed by If Yes, Give 1943–1943 Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced White Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) <u>Auto Service</u> 6 Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Pistorio Alberti Jennie Salvatore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrews Way Baltimore, Maryland <u>1220 St.</u> Wife Kathleen Alberti Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5-29-2010 Towson . Si na ure of Eureral Service Lidensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ON GESTIVE Physician disease or condition Medical resulting in death) Due to (or as a cons) ence of) Examiner Sequentially list conditions, Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 Impatient 2 ER/Outpatient 3 DOA 은 this 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 27. Manner of Dath 28c. Injury at Certificate: Natural (Month, Day, Year) Hospital or Attending 5 Pending 1 🗀 Yes 2 🗆 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 SZJ 57 ORN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 📗 🕕 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Lucille Jane Arndt 10:20 A M May 2010 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/11/1924 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min. 85 184-20-7959 Director Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the the Jical Examinar must be notified a 1XYes 2 □ No Director Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21001 USA 629 Walker 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 📉 No Specify. SpecifyWhite 3 Widowed W Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) a Grace Mott th and Men 7 is market Frank Albano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 McHenry St, Baltimore, MD 21223 Frank Arndt / Son pern it. Pages 1 and 3 Dep. rtment of Health Imp. rtant: If item 27 any injury or other tr 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2010 Harford Mem. Gdns. Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. En er the dish se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Examiner TRACHEOTORONCHITHS . ALLITE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine PNEUMONIA, PSEUDOMONUS burial-tran resulting in death) Last Due to (or as a consequence of): PNEUMONIA, MKSA attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CLOSTKIPIA PIFACILE ENTEROCOLITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CEREBRAZ. VASCULAR ACCIDENT 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? CHRONK ATRIAL 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours are:
The Funeral Director: Annetely filled in by the f investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Audien Newalisms (mo D08096 MAY 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FV LFCRD AVE BELAIR, MD 21014

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20/0 ROBERT BALLEY 8:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL annapolis ANNE ALUNDEL MEDICAL CENTER **Funeral** Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1**X**□ M 2 □ F Months Hours Min 0270771915 Director 212-09-4802 Vîrginia 95 Usual Residence of Decedent show with the Maryland 10a, State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Crownsville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 Sheridan Road 21032 U.S.A. filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. ö \$ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 2 K No 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the 9th Grade Long Shoreman steam ship trade Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ဂ raffs

I and 2 should be and of Health and Martiner. If item 27 is any injury or other? pe Obadiah Bailev Alberta Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Bailey (wife) 1300 Sheridan Rd., Crownsville, MD 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit, Page Department of Important: If any Injury or 4 Donation 5 Other (Specify) King Mem. Park 05/28/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Joseph H. Brown Jr. Funeral HOme
2140 N. Fulton Ave., Baltimore, MD 21217 cetich 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ POSSIBLE ACUTE MOCAPOIAL INFARCT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Date to for as a consequence of resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 No signed by the a d be detached f 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA Records, or Attending Physician; The law requires cate has been signated by page 2 should b Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗆 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: To the Hospital or Attending Physiswithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. မှ 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D6675 2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Xear) KAY 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Richard Franklin Brady 11:00AM 05 5 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Square osedale ar If Under 24 Hrs. Fimore Franklin Hospital Center 5. Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) 01/08/1945 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1**∑**M 2□ F Months Days Hours Min. 220-40-1421 65 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. I other than "natural", or items 23a or 28a-f show went, the Medical Examinar is ust be notified as Maryland 1 ☐ Yes 2 🙀 No Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9745 Bird River Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XNo If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>Ş</u> Specify: 3 ☐ Widowed 4 🏻 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Mechanic Can Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fishers is marked ott Kenneth Mills Clarice Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Clarice Warnick (Mother) 7 Contact Court, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory, Ind 05/29/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility nski Funeral home, P.A. 21. Signaturu of Funcial Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Each the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immolate Cause (Final disease or condition resulting in death) **Physician** ongestive heart /Medical Due (or as a consequence of): Examiner therosclerotic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 0.1.0 attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an autopsy certificate 1 □Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) P Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending investigation -1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide e Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 69540 M-D 25 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tigar Sul 6 204 Parkville ND 21234 SS13 Wal ham words Rd

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

26 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland		rtment of I			ental Hy	giene	001	n	161.07
			Decedent's Name (First, Midd	dle, Last)						2. Date of De		Con U 1		3. Time of Death
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	Exami		4a. Facility Name (If not institution	on, give street and number)			4b. City, Town, o	r Location of		1.1019		County of D		,0.
			Franklin Squa	re Hospital			Rose	dale	0		\mathcal{L}	balti	mp	re
	Funeral		5. Social Security Number	6. Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Under Hours		8. Date of Bir (Month, Do Novemb	rth av, Year)	9.	Birthola	ce (State or Foreign
	Director		217-26-4232	1 1 M 2 X F 7 9	9	Yrs.		,		Novemb	ér l	,1930	Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. Count	у Т	10c. City,	Town or Loc	ation						100	d. Inside City Limits
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	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. W	/as Decedent of H Yes, specify Cub	lispanic Ori	igin? (Spe	cify Yes or No)-	14. Race - A	merica	n Indian,
98	or it	F.	1 ☐ Never Married 2 ☐ Ma	rried 1 Yes 2 No	0		Tes, specify Cubi	Specify:		ncan, etc.)		Black, W	White, etc	
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۷. ۲	"nat	lete	(Specify only highe	nt's Education est grade completed)		16a. Decede	ent's Usual Occup ind of work done O NOT use retired	oation during most	t of workin	g	16b. Kii	nd of Busine	ss/Indu	stry
≥ 5	withi iene. tha n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cafet	eria Co	o k			Bai	lto. C	lity	Schools
	filed Hyg other ent,	BeC	17. Father's Name (First, Middle	, Last)				18. Mothe	er's Name	(First, Middle	, Maiden	Surname)		78.
Baltimore. Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparatment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To B	Gabriel DiPaso							Genove				
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Broad Itimore, N	Pages nent of nt: If I		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Gard	metery, crema lens of	tion (Name of atory or other place Faith		5-27-	2010	_	to. Má		.,
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			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	or complications that caused to	he death.	Do not ente	r the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		م ا	Approximate nterval Between
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	nsit	Ë	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for an a	MURRINGER)	maa arji							7	
MD.	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	nce of):							+	
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9	rtifica ng ph as th	/ed	JE EENALE.											
Box	eath certific attending p for use as t	an	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pregnanc	v			2	3d. Date of	,	
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Division of Vital Records,	Physician: The law requires that the death certific this certificate has been signed by the attending prail director, page 2 should be detached for use as it	d by	Part II. Other significant conditi	ons contributing to death but	not result	ing in the und	erlying cause give	en in Part I.				se contribute] No 3 □		cause of death?
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ţ	sician: The certificate l irector, page	a l	25. Was case referred to medica	ul _				26 Place	of Death	│ 1 □ Yes (Check only o		1 🗆 Y	es 2	∐No
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<u>.</u>	endli eath. or: A he fu	atic	2 ☐ Accident investi	igation		,,		Yes 2□N	Vo V					
ĕ	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of Injury building, etc.	y - At hom (Specify)	e, farm, stree	t, factory, office		28	3f. Location (S City or Tov	Street and vn, State)	d Number or	Rural F	Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical one)	Exeminer: On the basis of e	examinatio	n and/or inve	estigation, in my o	pinion, deal	th occurre	d at the time,	date and	place, and	due to th	ne cause(s)
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	2		30. Name and address of person	who completed cause of dea	ath (Item 2	3a) (Type, Pr	int)			, 1				
		.	Jr. Devedatta 31. Date filed (Month, Day, Year)	Saruate 900 6 2010 32. Rigistrar	O F	anklin	Square	. Driv	e 1	bultim	010	MD.	212	37
	Sta Registra		MAY 2	6 2010 Since	الما	B. A	arke							
			***************************************	4		- //								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 ear MATY 23 4:15 Kenneth Joseph \mathbf{P}^{M} Bunty Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death R TOWSON **Examiner** 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 🛛 M 2 🗆 F Months Days Hours Maryland Director 218-36-8359 Ĩ938 Dec. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 Everall Avenue 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married ¥ Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes, Give rryes, Give Army Res Specify White Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Carpet Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Bunty James Agnes Munche1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Lawrence Daughter 656 Sean Drive Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annunciation Cem 5/27/10 McSherrystown, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each of the death. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): sician and burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No g 🗌 Unknown P.O. I þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician; The law autopsy perform 1 Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2-No မ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 7. Manus of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 MOI Officialie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 6409 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Barbara Paulette Brock 110:10 2010 Medical MAN 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔽 F 1949^{ear} 219-52-6324 60 Yrs. **Director** MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Randallstown 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9714 Eustice Road 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. African-American 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Special Education Teacher 12th Grade Balto. City Public Schools Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth McDaniels Manson Brock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Enerv 1 and 2 s of Health item 27 9714 Eistice Road, Randallstown, Md 21133 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of 1 Important: If it any injury or or ŏ 1 Nurial 2 Cremation 3 Removal from State Arbutus Mem. Park 5-28-2010 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Fun-cal Form F.A. of Balto. Co. 21. Signature of Funeral Service Lie 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Methicillin resistant Staphylococcus aureus seeks Medical Due to (or as a consequence of) Examiner 1 years End stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral cinector, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 🔀 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💫 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 2 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May, 21, 2010 AT 2438946B6

Registrar
DHMH 17 Rev 7/2009

State

Memorial Hospital

Baltimore

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union

32. Registrar's Signature

Leah

Jonic &
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Susan Bubenko 2010 ar 21 2:15 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death North Arundel Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA **Funeral** 8. Date of Birth 1 □ M 2 🗓 F 89 Days Hours 2 /Mo3th Pay 29 1) 232-80-1333 Director Usual Residence of Decedent or 28a-f shov 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1238 Dicus Mill Road 21108 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Home Owner Be 17. Father's Name (First, Middle, Last) should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည John Bubenko Sr. Katherine Stefko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Theresa Duty/sister 1238 Dicus Mill Rd., Millersville MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/26/2010 4 Donation 5 Other (Specify) East Grove Cemetery Morgantown, WVa. 22. Name and Address of Facility 21. Signatu Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final STROKE Onset and Death Physician/ disease or condition mont Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Completed 1 Yes 2 10 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? certificate 2 L No 1 Tes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident
2 Accident
3 Suicide
4 Homicide 5 Pending work To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A 1 Yes 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date stoned (Month. Day, Year) 02009 OW) ddress of person who completed cause of death (Item 23a) (Type, Print) mo Mudlar 31. Date filed (Month, Day, Year) 32 Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4a, perPHYS#10e, 19b, perFH, C904, 6/11/2010, WS
State of Marytario, Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Brown Jr 05 2010 00a Claude Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Merrymount Drive Windscr Mills Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1**X**□ M 2 □ F Months Davs Hours Min Country) Director 216-50-0848 62 Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Xes 2 No NA Windsor Mill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be Completed by Funeral Merrymount 8416 21207 U.S.A. Drive permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry William T. Burnett Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade <u>Machine Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hester Freeman Claude Andrew Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Merrymount Mary Mount Drive, <u>Pamela C. Brown-Wife</u> 8416 Windsor Mills, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 5/29/2010 Baltimore, Md . Sign ture of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21215 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician Cance-Lung Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 S No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 2 No 5 Pending 24 hours after death Funeral Director; A 2 Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier trifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number 0,0550 65

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State Registrar 31. Date filed (Month, Day, Year)

Edelman

MAY 26

32. Reg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unit with the Conference of the Con

225 Greene St. Balkmore, MD 21281

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12 per fh 9904 6-2-10 yt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Alexander Bivins ΙI MAY 2010 03:27 A M Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral 02 19 1 X M 2 - F Days Hours 84 **Director** MD 219**-**12-3986 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a o , the Medical Examiner must be Funeral 1433 East Eager Street 21205 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 Yes No Black, White, etc. 1 Never Married 2 X Married ş Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Black Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade <u>Front End Loader</u> Beth Steel Corp. marked other event, Be be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file 2 other traumatic Henry A. Bivins Mary Ida Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is <u>Lizzie Bivins-Wife</u> 1433 East Eager Street, Baltimore, Md 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) son Forest Vet 5/26/2010 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner STENOSIS MITRAL AND ADRTIC Secrentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed attending physician and for use as the bunal-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant 9 Unknown 5 Other (specify) Year Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE LIVER FAIL URE 2 No 3 Probably 4 Unknown 1 Yes been signature Completed Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an cate has bage 2 s autopsy perform certificate 1 Yes Yes the Hospital or Attending Physician: Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred To the Hospina. .. within 24 hours after death.

To the Funeral Director: After a contact of the Funeral diled in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 1 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signa d title a Date signed (Month, Day, Year) 3545 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 7601 INDA BARR TOWSON MARYLAND 21204 DRIVE, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 23, Day 2010 Year Physician/ Phyllis Waldman Berman 5:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery 10631 Montrose Avenue If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr 19, Tear) 1 🗆 M 2 🛛 F New York 82 **Director** 060-26-9709 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Montgomery Bethesda 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 20814 10631 Montrose Avenue U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force ☐ Yes 2 🗓 No "natural", or ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed al Hygiene. d other than "natura" event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+Child Psychologist Researcher Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marke any injury or other traumatic to Abraham Waldman Sarah Ruth Pearlman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1070 S. 5th Street, Chambersburg, PA 17201 Marc A. Berman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory May 25, 10 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse Final Physician/ Interstitial Lung Disease disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Asthma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Immunoglobulia Deficiency 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No nours after death.

neral Director: After this certificat dilled in by the funeral director, pr 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 🗌 Yes 2 🗓 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work?
1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D42105 May 24, 2010

State

Registrar

Montgomery Ave., Bethesda, Maryland 20814

4550

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Christopher Duke, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Month 2:00 PM 24, Mary R. Brock May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7879 Nordau Court Howard Jessup Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 XX March 15 1942 68 MD 216-56-6587 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director MD Howard Jessup 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 7879 Nordau Court U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 XXo Specify: Specify: White "natural" Completed 3 XXVidowed 4 Divorced Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "r any injury or other traumatic event, the Manage. (Give kind of work done during most of working than Elementary/Seconday (0-12)
Grade 8 life. DO NOT use retired) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ross Edward Measley Leona Bolton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William K. French, III / son 120 Windy Road Gretna, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XXurial 2 Cremation 3 Removal from State Ivy Hill Cemetery 5/26/2010 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser 22 Name and Address of Facility al Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ₽hysician/ Cancer of Ovary disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the Unknown g Unknown ss been signed by til 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 XXVIo certificate 2**X**XNc 1 Yes Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 XXVo 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5XXResidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 XXNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. neral Director: Aft d filled in by the fur Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) thin 24 hours a the Funeral C Medical 💆 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

101

DHMH 17 Rev 7/2009

Registrar

7525 Greenway Center Drive

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Martin Weltz,

31. Date filed (Month, Day, Year)

D 23743

May 25, 2010

20770

Greenbelt, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28 tate of Manyland 1999 997267201 blenth and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BURRELL EDNART Medical 4a. Facility Name (if not institution, give street and ηumber) 4b. City. Town, or Location of Death 4c. County of Death Examiner TIMONE If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 9 M 2 D F Months Days Hours Min Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director BALTIMONE 1º Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NIA Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Pi Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number PALTIMENS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place, 1 PBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Lion see Name and Address of Facility 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ DEMENTIA disease or condition resulting in death) Years Medical Due to (or as a consequence of): Examiner MELI LOUS ABETES Sequentially list conditions. Examine Due to for sels consequence of trany, leading to immediat cause. Enter Underlying YPERTENSION Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant g Unknown Pregnant at time of death Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Sister residence မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending death. 2 Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065440 03 ,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

E

NY 2 6 201

31. Date filed (Month, Day, Year)

arka

REET

32 Registrar's Signature

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6.23PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC 8. Date of Birth **Funeral** ^{Year)}193<u>4</u> Aug. 23 1**23**M 2□F Months Days Hours **Director** 578-44-9713 75 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Prince Georges Clinton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8811 Aquone P1. 20735 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Fo Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 959 If Yes, Give 1 959 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: 3 Widowed 4 Divorced Specify: Completed 1963 **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dentist Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ဂ္ Department of Health and Ment. Important: If item 27 is marked any Injury or other. William Bullock Beatrice Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Bullock - Wife 8811 Aquone Pl. Clinton, MD. 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 5-22-2010 Brentwood, MD. 21. Signature of Funeral Service Licensee Marshall sof Funeral Home of Maryland, Inc. 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that the death certificate be executed attending physiclan and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate I performe 1 \square Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA this 6 Other (Spec 4 Nursing Home 5 Residence .onding. ...er death. **9I Director:** After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending injury 2 Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one person who completed cause of death (Item 23a) (Type, Print) State Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend # 5, 19a-b, per AB 2903 5/26/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day James Edward Beverly May 2010 P^{M} 16 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6903 Holabird Avenue Baltimore 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1⊠M 2□F Kentucky 66 Yrs. Director 216-42-1005 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inhortant: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evantment than must be notified and other. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director MD Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21222 USA 6903 Holabird Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1x∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🐼 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Beverly Sr. Lavenia Webster ပ 19a. Informant's Name/Relationship (Type. Print) Dr. Ali Sanai: 9. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6/30 6903 Holabird Avenue; Baltimore, Maryland 2 Holabird Avenue; Baltimore, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Robert S Wade State Anatomy Board; 655 W. Baltimore Street 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high at failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause in disease or condition resulting in death) **Physician** 648 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 2 No 25. Was case referred to medical exampler?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifi 29d. Date signed Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 6730 Ba 1to (TOLABIRD 32. Registrat's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Bergquist 2010 Clifford 7:55 A^{M} Charles May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chase Baltimore 24 Mango Trail 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, May 18, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 X M 2 □ F 19<u>38</u> Director 213-36-2636 72 May Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🕅 No Middle River Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21220 USA 24 Mango Trail "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc <u>გ</u> 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction General Contractor 10 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Jessica Witkowski Charles Bergquist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Mango Trail, Middle River, Md. 21220 19a. Informant's Name/Relationship (Type, Print) Susan Marie Bergquist Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 24, 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2010 Nature of Juneral Service Lies Conneity Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Rand . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician dise out OVUNam disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob o use contribute to the cause of death? Completed by 063110011 1 V Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 10 06 a 1 🗌 Yes 25. Was case referred to me examiner? 26. Place of Death (Check only one) Division of Vital funeral director, Be Hospital: Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 atural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 41399 10

State Registrar North Point 18 Wil

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who completed cause of death (Item 23a) (Type, Print)

was

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 1823 PN BEAM MELISSA AY Medical 010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death OHNS HOPKINS BAYVIEW MEDICAL LENTER BALDMORE If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) unk Funeral 1 □ M 2 🖾 F Hours Min March 30, Director 327-72-4727 33 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Frankford Avenue 21206 USA 12. Was Decedent Ever in U.SUNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status unk 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event. 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation UN (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Unit (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Johns19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hopkins Bayview Medical Ctr 4940 Eastern Avenue; Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state Signature of Funeral Service State Adas de Bourd; 655 W. Baltimore Street Baltimore, Maryland 21201 Wate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, BOWEL OBSTRUCTION disease or condition resulting in death) SMALL OMFLETE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Division for this a consequence off Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Day Month Year 5 Other (specify) Pregnant at time of death 2 No ed by the a detached f q □ Unknown 9 Unknown Division of Vital Records, P.O. cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Minpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

within 2

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32. Regis rar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RES-001

29d. Date signed (Month, Day, Year)

29c. License number

MARGARET CAVANAMAH-HUSSEY, M.O. 4940 EASTERN AVENUE. BALTIMORE, WARYLAND LIZZY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 39,11,15,16a&b,17,18&19a&b, Per, ANA BD G929, 7/31/2012 JH. State of Maryland, Department of Health and Mental Hyglene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) BURGESS 2010 05 Kobert 7 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Future Care Homewood Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 117 M 2 □ F Yrs. South Carolina Nov 20, 1935 74 247-60-2278 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2700 N. Charles Street 21218 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. un k13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married Specify: black 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Indust 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 8 Construction unk 0 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Edward Burgess Asa Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

807 Clintwood Court Baltimore, Md 21225

2700 N. Charles Street: Baltimore 19a. Informant's Name/Relationship (Type. Print)
Sarah Jane Burgess/wife
Future Care Homewood Charles Street; Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Si value of Funeral Service Licensee 22. Name and Address of Facility Board; 655 W. Baltimore Street rector Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cause (Final disease or ition resulting in death) Propenie Deck Due to (or as a consequence of): Remonst Sequentially list conditions, it is a large to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) huchent Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Priifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Examiner that the death certificate be executed Box 68760. P.O. Division or Vital Records, ne Hospital or Attending Pin 24 hours are death. within 2.

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 Is marked other any injury or other traumaire

Physician /Medical

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Director

Funeral

Completed by

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· HASHMI

29c. License number

31464

MD 821 N. EUTAN ST SINK 300 BALTIMORE MD 21201

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 20ÎÖ GLADYS 03:21P BERMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕻 F Days Months Hours Director 85 Yrs 1270871924 NY 078-18-1316 Usual Residence of Decedent Page 1 and 2 should le filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The file mat and the starts if it is man ed other then "natural", or items 23a or 28a-f show jury or other traumatile event, the Me. It all Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No **BRONX** BRONX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232nd STREET, #20F 10463 290 W. USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married Ś Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ZWELL SARA FELDSTEIN CHARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 RIDGELEIGH ROAD, BALTIMORE, MD 21212 PAUL BERMAN / SON permit. Page 1 and 2 Department of Health Important: If item 2: any Injury or other t once, Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗖 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) WELLWOOD CEMETERY 05/26/2010 PINELAWN, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant : 9 Unknown Pregnant at time of death the After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No WOSDice ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Director: After thi 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔽 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, che Funeral Dire Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Robert L. Cox, Sr 2010 8:41 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1113 Hendrix Court Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1**X**) M 2 □ F Months Days Hours Min. 08/16/1931 Director Yrs 216-28-7003 78 Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD Baltimore Baltimore 1 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with 1 23a Funeral 3826 Perryhurst Place U.S.A. 21236 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? X Yes 2 □ No 0 Black, White, etc. "natural", or Completed by 1 Never Married 2 Married If Yes, Give Korean Year or Dates Hosti 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12 other Financial Planner Financial Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H P Esther Wallace John Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 6743 Glenkirk Road - Baltimore, Maryland Brad Cox (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. 05/24/2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland ass 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death of o not enter the Immediate Cause (Final Physician/ monin disease or condition Medical resulting in death) Examiner sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnar 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Day Year Pregnant at time of death signed by the a Id be detached for 9 🗌 Unknown 9 Unknown Part II. **Otifer significant conditions cont**ributing to death but not resulting in the unflerlying cause given in Part I. 23e. Did tobacco use contribute to to Completed by d/ne 4 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autons page 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred t funeral director, Be edical 26. Place of Death (Check only one) examiner Hospital: 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print 750505 LER DR. #308 31. Date filed (Month, Day, Year) strar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Edward COLGAN 8: 23 AM Medical au 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center University Baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

MD If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗖 M 2 🗆 F Months Days Hours Min. Sept 12 1953 Director 217-56-3689 Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 27849 Little Park Road USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Ramp Supervisor Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Colgan Eleanor Carbough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) 72½ Bond Street, Westminster, MD 21157 Nicholas Strong Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, alture. List only one cause on each line. 23a. Part 1. Enter the shock, or heart fail Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of): [/]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗆 Yes 2 🗆 No 3 🗀 Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 XNatural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) P24405-24, 2010. May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My-Le Ngyen

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year) MAY 2 6 2010

Box 68760

P.O.

Records,

of Vital

Division

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth 5 2ďfb Joseph Castle 5:00 A M Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Guardian Angels Assisted Living Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 □XM 2 □ F 77 Months Days Hours Min Director 219-28-6537 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-1 sho important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 113 Mapledale Ave. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Joseph P. Castle Sr. Marjorie Osbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus S. Castle/son 113 Mapledale Ave Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory 5/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Catonsville MD 21. Signature of Funeral S 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Day Year as been signed by the 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed Yes 2 🗐 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 은 1 Yes 2 4 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. Director: Aft 1 🗌 Yes ☐ Accident Investigation 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and 2009 ad address of person who complete cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

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32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2I, 2010 May Judy Evalene Clingerman 7:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7606 Laurel Ridge Court Prince George Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Days Min. West Virginia Director 1942 68 Yrs. 213-40-3761 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7606 Laurel Ridge Court 20707 U.S.A within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ò <u>م</u> 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 e filed within 72 hours after Ital Hygiene. ed other than "natural", o 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Dayton Long Murphy Nina Sweitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar G. Clingerman /spouse 7606 Laurel Ridge COurt, Laurel, Maryland 20707 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory May 22, 10 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Man M00773 Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused shock, or heart ignure. List only one cause on each line Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician/ disease or condition resulting in death) MITASTATIL ramo Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown for 5 Other (specify) Month Day Year Pregnant at time of death the 9 Unknown signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate Yes 2 N 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' ဂ္ဂ 2. No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 124 hours after death. e Funeral Director: Aft bleted filled in by the fun Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) D

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State Registrar 31. Date filed (Month.

Ittui

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21044

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIN

32. Resistrar's Signature

Brener

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 3 per doc 9904 6-1-10 and Mental Hygiene
State of Maryland / Department of 1-210 and Mental Hygiene

_		For State Registrar	, or iviaryiand		tificate of E		, ,	eg. No. 2 0	161.25		
Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Marie Elizabeth	Cice	ro			2. Date of Death		3. Time of Death 5:55 p & M		
Med Exam		4a. Facility Name (if not institution, give street and institution)			4b. City, Town, or	Location of Death	•	4c. County of Dea	th		
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign		
Directo		Usual Residence of Decedent	7-	Yrs.			Mayoch Dez:	3,7 1919 Ma	ry7and		
// // // // // // // // // // // // //	rector	MD 10b. County Harford	10c. City,	Town or Loc Monk 1					10d. Inside City Limits 1 Yes 2 No		
with the N 23a or 28	Funeral Director	10e. Street and Number 2409 Houcks Mill Road	<u>l</u>		10f. Zip Code 211	11	1	0g. Citizen of What Co	ountry?		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ģ	1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? es 2 X No Give r Dates.	If	Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
Baltimore, Maryland 21215-0036 oernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Examination.	Completed	15. Decedent's Education (Specify only highest grade completed in the comp	e (1-4 or 5+)	(Give k life. DC	ent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of work	king	16b. Kind of Business Own home	Industry		
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, Mary nd 2 should eatth and n n 27 is me eer trauma		19a. Informant's Name/Relationship (Type, Print) Francis C. Cicero-son						City or Town, State, Zi,			
limore Page 1 arment of He tant: If iter iury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Dul	ce of Dispos netery, crem aney	sition (Name of natory or other place Valley	5/2	Date :	20c. Location - City or Timonium			
Balt permit Depart Impor		21. Signature of Funeral Server Licensee Will	iam G . D		. Name and Addres			n Funeral 21204	Home, Inc.		
Physician Medica Examine	il r	Sequentially list conditions, if a sy, leading to himediate cause. Enter Underlying	at caused the death. each line. to (or ast consequent to (or ast consequent to (or ast consequent)	Do not ente	r the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death		
8760 ificate be executed by physician and as the burial-transit	cal Examiner	Cause (Disease or linjury that initiated events c.	to (or as a conseque	nce of):							
	Medical	IF FEMALE:									
Division of Vital Records, P.O. Box 68 for the Hospital or Attending Physician: The law requires that the death certifully at hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	outcome of pregnand tve Birth 2 Fetal or regnant at time of dea nknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year		
ords, P.O. Boy requires that the despensioned by the should be detached	è	Part II. Other significant conditions contributing t	o death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
So to the first of											
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Division al or Attences s after deat I Director: d in by the	Certificate:	3 Suicide 6 Could not be	ace of Injury - At hom ilding, etc. (Specify)	e, farm, stre		Yes 2□No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,		
Division of Vital To the Hospital or Attending Physician: within 24 hours after detth. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifler (Check only one) 1	basis of examination a	and/or investi	igation, in my opinio	n, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.		
To 1		29b. Signature and title of certifier	CU		29c License		3	MAY 2	n, Day, Year) 2 2010		
		30. Name and address of person who completed of	ause of death (Item 2	3a) (Type, P) 6701	N. Ch	orles s	inst Jours	2 2010 N MD		
St Regis	ate trar	31. Date filed (Month, Day, Year) - 32	. Registrar's Signatur		arke						

		For	State o	of Mar	yland	•				and M	lental Hy	/gien	е	1.0	1 21 07
		1 - State Registrar Certificate of Death Reg. No. 2											16421		
Physicia: Medic		Decedent's Name (First, Middle ALBERTA	, Last) CHRISTIA	N							2. Date of Do Month May	17)ay 2	010	3. Time of Death 2315 p M
Examine		4a. Facility Name (if not institution,	give street and num	nber)					Location	of Death			c. County		·
, A		Prince Georges 5. Social Security Number	Hospital		last	In factor along a	Che If Unde	verl	-y If Under	- 24 Um	0.001 (0)		Princ		
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ihow at	. 1	Usual Residence of Decedent 10a. State 10b. County	_	10	0c. City, 1	Town or Loc	ation							1	0d. Inside City Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 A No /e	_	If	Yes, spec	ify Cubar	Specify	n, Puerto I	Rican, etc.)			k, White, e	
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permit Depar Impor any ir		21. Signature of Funeral Service L	icensee AU	PA.	12	Ma 4.3	Name 18 308 S	dAddres Suit1	s of Facili and	ëral Rd.	Home of Suitl	of M	aryla MD.	nd, 2074	Inc. 6
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Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)				Fail	ıre								Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, out 1 Live 4 Preg 9 Unkr	Birth 2 [nant at tir	Fetal d	leath 3 🗌	Ectopic Other (sp		у				23d. Date Mor	e of delive oth	ery Day Year
that th	y Ph	Part II. Other significant condition	ns contributing to c	leath but i	not result	ing in the ur	derlying	cause give	en in Part	ı.	23e. Did	tobacco	use contri	bute to th	e cause of death?
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after of Direct												r or Rural	Route Number,		
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To the comp		29b. Signature and title of certifier		10 1110 1000		^		. License		o and place	o, and duo to t		ate signed		
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10V		30. Name and address of person to George C. Ha				3a) (Type, Pr orbes		. Su	ite :	D La	nham,	MD.	2070	6	
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Registra	ir	MAY 2	6 2010	Enew	a,	B. A	arke	_					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2010 Cascio May 24 5:24 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Months Days Hours Min January 12, 1927 1 □ M 2 🂢 F Maryland **Director** 216-20-4135 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1813 Old Eastern Avenue 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Claims Adjuster Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stopford Madeline Stopford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Gmurek 1813 Old Eastern Avenue, Essex, Maryland 21221 Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cardens of Faith Cemetery May 27,2010 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pyneral Service Licen 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Sollers Point Road, Dundalk,Md. 7110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, n Wa Cranin disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner dAys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi). attending physician and I for use as the burial-transif Hospital or Attending Physician: The law requires that the death certificate be executed Dementia Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day 5 Other (specify) Year 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disorder Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner . 1 Yes Hospital: Other: 2 | No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) NOSP (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury ☐ Natural 5 Pending 04:45 AM MAY 17, 7010 1 ☐ Yes 2 No INNITNESSED FALL 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Nursing 7232 German HURD home 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signaty d title of certifie 29c, License number

State

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Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05/24/ Carroll Fremont Coomes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Annapolis Anne Arundel Medical Center A.A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Hours 219-22-8482 Director 83 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Arnold 10b. County Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 336 Buena Vista Ave 21012 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. WWII Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 yrs (1-4 or 5+) Elementary/Seconday (0-12) Gov't Contractor Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Coomes Elma Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose A. Coomes Wife 336 Buena Vista Ave Arnold MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Atlantic Crem 5/25/2010 Glen Bernie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser. Thomas AllenP.A 7090Ridge Hanover MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Se disease or condition resulting in death) Medical Due to (or st a consequence of): Examiner colite Sequentially list conditions. if any, leading to immediate cause. Et al. Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗆 Yes 1 Impatient 2 ER/Outpatient 3 28a. Date of injury (Month, Day, Year) 28b. Time of injury 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director; After thi completed filled in by the funeral i 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie mi) D24804 address of person who completed cause of death (Item 23a) (Type, Print)

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10d. Inside City Limits

Approximate Interval Between Onset and Death

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Year

1 Yes 2X No

DHMH 17 Rev 7/2009

State Registrar KOBOIT

31. Date filed (Month, Day, Year)

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Wayne Clark Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	16431
State of Maryland / Department of Health and Mental Hygiene	0 7 0

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	hysicia	an/	 Decedent's Name (First, Middle, L 							2. Date of Dea Month	Day	Year	3. Time of Death
<i>l</i> ledical	Examı		Wayne Timothy 4a. Facility Name (if not institution,		•					May 6, 20		County of Deat	0026 hrs
			Harbor Hospital Center	b. City, To		cation of Dea	itn		Balti				
F	uneral			Salamore.									irthplace (State or
	rector			Months Days Hours Min. Fore									
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	any		10a. State 10b. County		• • •	own or Location							10d. Inside City Limits
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Maryl	28a-1 d at 9	Director	10e. Street and Number				10f. Zip C	ode			10g. Citize	n of What Cou	untry?
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MD Shor	and 7 is	-	Jaime Renee Cl		er			•		altimor			
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Baltimore,	Department of Important:	ł	21. Signature of Funeral Service bio			22. No	ame and A	ddress of	Facility S	implici	ty C	remat	ion & Fun MD
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760,	g physician the burial -	ĕ	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy						Date of delive	10.00
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the H	within 24 h To the Fur completely	ledical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and market death occurred at the time, date and place, and due to the cause(s) and market death occurred at the time, date and place, and due to the cause(s) and market death occurred at the time, date and place, and due to the cause(s) and market death occurred at the time, date and place, and due to the cause(s) and market death occurred at the time.									e, and due to	the cause(s)
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			U_M)_					O.C.M	l.E.		May	6, 2010	
			30. Name and address of person w	no completed cause of de	eath (Item 2	23a)							
	_		Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Medic					Baltimore,	MD 21201			
	9	tate	31. Date filed (Month, Day, Year)	6 2010 32. Registrar	's Signatur	B. 4	back						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eleanor Caroline Degano Mav Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Maples of Towson Assisted Living Balto. Towson 5. Social Security Number 8. Date of Birth If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 7. Age (In yrs. last birthday) 1 M 2 F r 3.192 Months Days Hours Min Month, Day, Ye November 216-44-0823 98 Yrs. Director Usual Residence of Decedent 10a. State 10b. County death with the Maryland the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 28a-f Md. Balto. 1 Yes 2 No Parkville 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? items 23a Funeral 8304 Nunley Dr. Apt.C 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. filed within 72 hours after 1 ☐ Yes 2 No Specify: White Specify "natural", 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Teacher Education 8th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is many injury or other. 2 Antonio Pokorny Antonia Kopocka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia D. Bedfort Niece 6510 S. Charter Rd. Apt.G Glen Burnie, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Bayview -24-2010 Balto. Md. 4 Donation 5 Other (Specify) Signature of Fineral Sep Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Cardiovoscular diseare Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav 2 🔼 No 1 ☐ Yes 2 ₽ 9 ☐ Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown disease Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 X No 70 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) After this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month Day Year) D0061485 Den 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franking 59. Dr. BMShra T-AL-A22awi, m)/9/03 franking 59. Dr. 3

State Registrar 31. Date filed (Month,

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland / Dapartment of Jeath and Manyland / Dapartment of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TWORE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** 1 M 2 F Days 214.44 662 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- " any injury or other traumatic event." 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Baltimore 1 Yes 2 No Baltimore Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Maryvale 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Black δ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Howard County Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public schools 12th grade NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Smith Davis, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Christine Davis Maryvale 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/17/2010 Windsor Mill, MD King Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughor C. Greene Funeral SVCs 21. Signature of Funeral Service Licensee iberty Road Randallstown, MD 21133 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. 23a. Part1. Enter the shock, or hear Due to (or as a consequence of): 15 EMST Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) キンカペコッ 名の Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X∏ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FA/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kandol

31. Date filed (Month

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37 Registrar's Signature

Court Rd

Randallstown

1 - For Amend Items 17,18,26 per in dr., 8903,05/26/2010diffental Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Day 8:50 AM 2010 Richard H. Decosta 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1000 Magnolia Woods Court Edgewood ocial Security Number If Under 1 Year | If Under 24 Hrs. Birth place (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. Months 029-30-6294 Hours sept. 25, 1942 1**∑** M 2 □ F 67 Mass. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Edgewood 1 🗌 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Magnolia Woods Court 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married à AfricanAmerican If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction 12th Be 18. Mother's Name (First, Middle, Maiden Sumame) *** Ethel DeCosta 17. Father's Name (First, Middle, Last) ပ Benjamin DeCosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Jackson /daughter 1000 Magnolia Woods Court Edgewood MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory 5/21/10 Baltimore MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTURE PULMUNARY disease or condition resulting in death) 1040 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. F. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 R/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 5/21/2010 DALOUES CONDUXY, MD POUSSOZY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMUR, MD 21237 3001 SOUTH HAMBOR HUSPITA L HINDUSE 31. Date filed (Month, Day, Year) 3. Registrar's Signature State barker MAY 26 Registrar

				partment of Health and I Certificate of Death		ene g. No. 2010	16434	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physici: /Medic		Phyllis Diedrick		Month May	18 Year 2010	7:00 P ^M	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	n	4c. County of Death		
			Hospice of Queen Annes	Centreville		Queen Annes		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Jan 11,	Year) Cou	place (State or Foreign ntry) York	
4	DW T		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits	
Mony	-f sh	to	MD Queen Annes Queens	stown			1 ☐ Yes 2X No	
4	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?	
4	23a o	a	3201 Bennett Point Road	21658		USA		
died within 20 hours offer doots with the Mandard	permit. Tages I and a Should be lined within 72 thous after beath with the Matyrat permit if Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto □Yes 2☒No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.	
2-0030	atura leal E	ted	15. Decedent's Education 16a. De	ecedent's Usual Occupation	. 16	6b. Kind of Business/Ir	dustry	
171	than "n	Completed	College (1-40r 5+)	ive kind of work done during most of work e. DO NOT use retired)	king	1		
א הקונו בו	Hygie ther 1		17. Father's Name (First, Middle, Last)	eacher 18 Mother's Nam	ne (First, Middle, Ma	education	1	
משטק קאפיייני	ental ental cedo	o Be	Howard William Habecker		Katherine	,		
X	mark mark	은		ailing Address (Street and Number or Ru			n Code)	
N S	alth a 27 is er trau	1	1	201 Bennett Point F				
Dalumore,	ment of He ant; If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	sposition (Name of crematory or other place)	Date 20	Oc. Location - City or T	own, State	
Dall	Depart Import any inj		21. Signature of Forecal Sension licensee Ronald S. Wade, Virector	22. Name and Address of Facility State Anatomy Boar Baltimore, Marylar		. Baltimore	Street	
	hysician /Medical		23a. Part Enter the dilease, or complications that caused the death. Do not shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
E	xaminer							
70	git S	Examiner	Sequentially list conditions, if any, leading to immediate cause. Life Underlying Cause (Disease or injury that initiated events					
icate be executed	physician and s the burial-transit	хаш	Cause (Disease or Injury that initiated events resulting in death) Last C					
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ificate	g phy:	edical	d					
To the Hospital or Attending Physician: The law requires that the death certif	signed by the attending p	hysician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	ery Day Year	
b, F	ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	icco use contribute to	he cause of death?	
Squire duine	been sig				1 ☐ Yes	2 i3 No 3 ☐ Pro	bably 4 ☐ Unknown	
The law re	certificate has be ector, page 2 sho	Completed			24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of	
Sicial	nis certifica director, p	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	th (Check only one)		11-00-0	
5 g	er this	T0	27. Manner of Death 28a. Date of Injury 28b. Time	tient 3 1 DOA 4 1 Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Special	N) MOSPICE	
	ith. r: After th e funeral	ation	1 Natural 5 Pending (Month, Day, Year) Injur 2 Accident investigation	e of 28c. Injury at y Work? M 1 ☐ Yes 2 ☐ No	Edd. Dedenide now	injury occurred		
taj or Atte	within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,	
he Hospi	in 24 hou he Funer pletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, di and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the car irred at the time, dat	use(s) and manner as te and place, and due	stated. o the cause(s)	
ان ان	To 1	Z	29b. Signature and title of certifier **Ellowing was a signature and title of certifier an	29c. License number	290	d. Date signed (Month, 5/19/20	Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Typ. STV AVT E. SELONICK, MO 31. Date filed (Month, Day, Year) MAY 26 2010 Consumer of the second secon	OO Bestgate R	d. Ann	apolis, u	16 rd. 21401	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrary Signature	1. Sal				
SHALL	1 17 Ray 1/20	001		1 /				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elliot Eckert 5 2010 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL SA45bUP HICOMICO If Under 1 Year If Und 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 K M 2 □ F 578-46-2782 Nov 1934 NewYork Director 75 Usual Residence of Decedent 28a-f show 10a, State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medica Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 8205 Arden Drive USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1952-Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 white Hygiene. other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 1970 Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) fireman DC Fire Department permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Joseph Eckert Sylvia Michelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Eckert/wife 8205 Arden Drive; Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ិន្និក្សាដែល Addat ៩កែឡាកែងoard; 655 W. Baltimore Street Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Fi uee (Final Physician/ ASCVI) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 ☐ No 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available cate has page 2 s autopsy prior to completion of cause of death? performed Yes 2 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? injury 5 Pending Division Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 147094 5/20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sheet 1415 S. DIVISION VATERAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:428 Physician/ 2010 RRMAN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner A Medic enter TIMORE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** 049112 / To 29 Hours 1 X M 2 □ F S. Carolina 80 Director 249-42-1307 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items on any injury or other traumatin 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 X Yes 2 No Baltimore N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21217 1911 Cecil Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2X No Specify. Specify: Black 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 6b. Kind of Business Industry Shaeffer Meat (Specify only highest grade completed) Elementary/Seconday (0-12) Callege (1-4 or 5+) Packing Co. Driver 5th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rhodia Linnen Henry Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3025 Brandonwood Rd., Florence, S.C. 29505 Bertha Grimage(Niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Olive BC Cem. 05/29/10 Georgetown, S.C. 4 Donation 5 Other (Specify) 21 Alame and Address of Facility Own Jr., Funeral Home 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) monice Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Erner Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last cal Division of Vital Records, P.O. Box 68760 Physician/Medi 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Day Yea in the past 12 months? Month 1 Yes 2 No n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 No After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital: Other: 2 No ည 1 Yes 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

10 NORTH G

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar¥ Signatu

VAUGHAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J. 2010 Month 5:28 PM arren 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Cons Stimore City N/A 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗀 M 2 🗆 F Months Hours Min. 0673071957 Maryland 220-64-5896 52 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No N/A BAltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 McElderry St. 21205 U.S.A. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married ☐ Yes 2X No 1 Yes 2 No Specify: If Yes, Give Specify Black 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Bounty Hunter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Addlean Felder L. SHorts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 McElderry St., Baltimore, MD 21205 Addlean Brown(mother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) [Oseph Brown F/H Inderematory 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/02/10 Baltimore, MD ²² Name and Address of Facility Joseph H. Brown Jr. FUneral Home 2140 N. FUlton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of): years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Examiner

Funeral

Director

or 28a-f shov

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of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical I

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Page 1 and 2 shment of Health a

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Baltimore, Maryland 21215-0036

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Physician/Medical

Completed by

Be မ

Certificate:

Medical

IF FEMALE

sician and burial-trans ng physician as the burialthat the death certificate be nding p signed by the a Hospital or Attending Physician: The law requires s been sign page 2 certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir this

Division of Vital Records, P.O. Box 68760

hispatitis C		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?
5. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
17. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	n (Month, Day, Year) Injury work? M 1 Yes 2 No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to determined	1 28a Place of Injury - At home form etreet factory office	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	sician: To the best of my knowledge, death occured at the time, date and place, and	

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1871728700

29d. Date signed (Month. Day, Year) 24,2010

Cibson State

29b. Signature and title of certifier

Wh Greene Street Britimore, MD

31. Date filed (Month, Day, Year)

MAY 26 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month S. Fletcher Harriet 05 2010 Medical :00a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Magnolia Manor Assited Living Catonsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours **Director** 87 213-20-7488 MDUsual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 White Chapel Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates Black Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ould be filed within 7, and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 2yrs Secretary State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raleigh J. Smith Harriet Summerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Edwards-Niece 3502 White Chapel Road, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/28/2010 <u>Western Star</u> Baltimore, Md Signature of Juneral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21a. Part 1, Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme late Cause (Final disease or condition resulting in death) ARTERIOSCLEROFIC VASCULAR DISEASE Onset and Death Physician/ Medical Examiner DIABETES MELLITUS TYPE IL Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 4 ☐ Pregnant
9 ☐ Unknown P.O. I ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. 144 PERTENSION ESSENTIAL Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sign ALZHEIMER 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Assited Hospital: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Watural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Transformer To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Transformer To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Transformer. (Check 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) サ*ス7151* MD 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYNOLD DEPESTAE 3100 LORD BALTIMORE DR # 110 BALTIMOREMD 21244 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 05 Sara Estella Fleming 2010 9:00a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4202 Maine Ave Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours Min 212-22-0787 90 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD NA Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4202 Maine Ave 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. b 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. Specify: Black Completed 3X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. Baltimore City life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade Custodian na Public School permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Dorsey Lola Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5113 <u> Bharon_Holland-Granddaughter</u> Frederick Road, Baltimore, Md 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/28/2010 Cedar Hill Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H Wes 4300 Wabash A West Ave, Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by COPO or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? certificate I ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 \square No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1-Natural injury work? 1 ☐ Yes 2 KNo 5 Pending Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State, To the Hospital Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of mamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certify g Nurse Practioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

State Registrar 30. Name and address of

31. Date filed (Mo

cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 10:05-PM OWARD MA 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 12, 1964 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Months Days Maryland 46 218-86-4726 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Dedical Evantions runst be notified at 1 XYes 2 ☐ No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 21224 USA 1716 Dundalk Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: White 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7% th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Sporting Good Store Sales 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Shrader John C. Forbes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; if item 27 is rr any injury or other traum once. 21052 7617 Chestnut Avenue, Fort Howard, Maryland Denise Chaney Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition May 24, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 15 ☐ Other (Specify) 2010 21. Stonature of Service Lig Connelly Funeral Home Of Dundalk, P.A. ens 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final JESPIRATO! **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ DUSPHACTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No al or Attending Physician: 3 safter death.
Il Director; After this certifica od in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA bi co Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred -1/ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide e Hospital on 24 hours af e Funeral D 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number nn سافاتانك 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28 MD 2101 PASNEEM 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 26 2010 Registrar

10-03953 Michael Fleming

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 16442

monaer rieming		1- For State Registrar Gratificate of Deat		, ,	teg. No.	0 04
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) Michael Duane Fleming		2. Date of Dea Month May 24, 2	Day Year	3. Time of Death 0620 hrs
			Town, or Location of Deat		4c. County of Dear	h
Funeral Director		5. Social Security Number 6. Sex 1 Month 1 M 2 F 55 Yrs.	ler 1 Year If Under 24Hr	s. 8. Date of Bi	rth (MM/DD/YYYY) 9. Bi	rthplace (State or gn Dountry) MD
ind show any ace.	ŗ	Usual Residence of Decedent 10a. State 10b. County Har ford Aberdeen				10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 762 Everist Dr. 210			0g. Citizen of What Cou	Intry?
after death wi	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specification of the second of the sec	ent of Hispanic Origin? (Sfy Cuban, Mexican, Puerto	o Rican, etc.)	White, etc. Specify: Wh	
5-0036 ted within 72 hours Hygien from "natur other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of wor	Occupation (Give kind of tking life. DO NOT use ref	work done tired)	Golf	Industry
1215- Id be filed Aental Hyg narked oth	<u>ا ھ</u>	17. Father's Name (First, Middle, Last) Zone Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Patrici (Street and Number or	a Byn	Maiden Surname) Per City or Town State	Zin Code)
ore, MD :		Doma Fleming / Sister 762 Ever	ist Dr. Abe	rdeen, M	1001	
Page nent		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specific:	Gardens 5/2	8/2010	20c. Location - City or Aberdeen,	MD
Balti permit. Departn Importi injury (21. Signature of Funerat Service Licensee 22. Name and January 333	Address of Facility Carge Function So Parke St	eral Hon 4. Abend	re, P.A. ken, MD 2	1001
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	f dying, such as cardiac o	or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death
	اج	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
d ansit	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED	-			-
ox 68 th certifi attending or use as t	sician/	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 2 past 12 months? 1 Yes 2 No 9 Unknown 2 Unknown 2 Other (Spec	3 Ectopic pregna	ancy	23d. Date of deliver) Day Year
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rds, P.(requires that been signed hould be deta	ompleted	Hepatitis		1 ✔ Yes	an 24b. Were au	topsy findings available
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be its control of the funeral director.	ا د	25. Was case referred to medical	6.Place of Death (Check		med? death?	s 2 No
F Vita	0 0	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	OA Other Nursin	ng Home 5	Residence 6 🗸 Other	: Scene
Vision of or Attending Ph. Ther death. Director: After I in by the funeral	Certification:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	8c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
Divis Hospital or A 24 hours after Funeral Dire stely filled in b		3 Suicide 6 Could not be determined 29e. Place of Injury - At home, farm, street, factory, (Specify)		or Town, St		
Di To the Hospital within 24 hours a To the Funeral I	ig	Certifying Physician: To the best of my knowledge, death occurred at the cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	ime, date and place, and opinion, death occurred a	due to the cause at the time, date a	e(s) and manner as state and place, and due to the	ed. e cause(s)
		296-Signature and title of certifier 29c.	O.C.M.E.		29d. Date signed (Mor	oth, Day, Year)
	[3	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD	21201		
Stat Registra		31. Date filed (Month, Day, Year) MAY 2 6 2010 32 Registrar's Signature Agarete				

		Plea	ase Type or Pri					-		.egible.		
		For State	State of Ma	aryland .		artment of F tificate of D		Mental Hy	giene			
		Registrar 1. Decedent's Name (First, Middle	, Last)		Cer	lilicate of L	reall i	2. Date of De	Reg. No.	2010	3. Time of Death	
Physicia Medio		John Daniel	Goldberg S	r.				May 26	, 2010	Year	7:10 A M	
Examin		4a. Facility Name (if not institution, 7507 Clearlake				4b. City, Town, or Middl	Location of Death e River	h	4c. Co	ounty of Death Balti		
Funeral Director		5. Social Security Number 220 20 1915	6. Sex 1 M 2 □ F 82	e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 8,	th 1928	9. Birti Çou Ma	nplace (State or Foreign ntry) ryland	
how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation					10d. Inside City Limits	
//aryla 8a-f s tified	recto	Maryland Balti	more	M	1iddl	e River					1 🗆 Yes 2 🏝 No	
with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 7507 Clearlake	Lane		_	10f. Zip Code 212	20		10g. Citizer	untry?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	If Von Give 1	ver in U.S. 946/48	13. V	Vas Decedent of Hi f Yes, specify Cubar	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
iin 72 hou ie. han "natu e Medical	Completed		nt's Education est grade completed) College (1-4 or 5		(Give I life. D	lent's Usual Occupa kind of work done d O NOT use retired)	luring most of wor	rking	16b. Kind of Business Industry Baltimore, County			
ed with Hygier other t	Be C	12 17. Father's Name (First, Middle, L	lasti		P	olice Off	18. Mother's Nar	ma /Firet Middle			County	
be file fental rked c	70	John Thomas Gol					Margaret	, ,		namej		
d 2 should alth and N 27 is ma		19a. Informant's Name/Relationsh Bobbi Boss (Dau				ng Address (Street a						
Page 1 and ment of He and: If item ant: If item ury or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tion - City or 1	Town, State Maryland							
permit. Depart Import any inj once.		21. Signature 6 Funeral Service L	icosee Bush		22 B:	. Name and Addres ruzdzinsk 407 Old E	s of Facility i Funera	al Home	P.A.	N/=1 -		
		23a. Pag. 1. Enter the disease, or	complications that caused	the death. D						Maryıa	Approximate	
Physician/ Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	over a consequence	0 6 5 ce of):	tructué	Pulm	ruy D	seis	~	Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that infliated events resulting in death) Last	b. Due to (or as a Due to (or a)									
cate be e	edical		d									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal de	eath 3 🗕	Ectopic pregnanc Other (specify)	у		230	d. Date of deli Month	very Day Year	
ires that the signed by detail	þ	Part II. Other significant conditions of the second significant conditions of the sec					en in Part I.	23e. Did t			the cause of death?	
w requ s beer 2 shou	Completed	Hypertens	dernisi		-			24a. Was		24b. Were auto	opsy findings available ompletion of cause of	
The la ate ha	Com	periphera	e vaseula	v Du	eas	e		autoj perfo 1 🗆 Yes	ormed?	death?		
ician: certific ector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	ace of Death (Che					
y Phys er this eral dii	e: <u>1</u> 0	27. Manner of Death	28a. Date of inju	ent 2 ER	b. Time of	t 3 □ DOA 28c. Injury	4 ☐ Nursing F at	lome 5 🔀 Resident			<u>(y)</u>	
ending eath. or: Afte he fun	ficat	1 X Natural 5 ☐ Pendir 2 ☐ Accident Investir 3 ☐ Suicide 6 ☐ Could	gation	(, Year)	injury	M 1 □	? Yes 2 No					
tal or Attress after de al Directo ed in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ry - At home :. <i>(Specify)</i>	, farm, stre	eet, factory, office		28f. Location (S City or Tox		umber or Rura	al Route Number,	
he Hospi iin 24 hou he Funer ipleted fill	Medical	(Check 2 Medical E	p Physician: To the best of examiner: On the basis of e. nurse Practioner: To the	camination an	d/or invest	igation, in my opinio	n, death occurred	at the time, date a	and place, and	d due to the ca	ause(s) and manner stated	
To vitt		29b. Signature and title of certifier Musel C	Harasic	-			8097		51	igned (Month,)	
NY		30. Name and address of person address of person and address of person a	who completed cause of d	eath (Item 23	a) (Type, P HPh			oute 108	1 BA	elt.	ud. 21237	
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 20b, perFH, G903,5/2672010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 **Physician** CZALES ANNIE 4:55 PM MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-09-16 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗓 F 220-36-0777 94 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tre Nedlen Fyaminer must be notified ■t Director Wow 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1806 Sherwood Avenue Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, et African Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates ð Specify: Specify: American 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 12th Grade Homemaker Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearlena Robinson Davison James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 East 4th Street Blades, Delaware 19973 Helen E. Young-Daughter 20b. Place of Disposition (Name of Baltimore a Cemelre of Sarrison Forest 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-29-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funetal Se was Livensee 638 N. Gilmor Street Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Bleeding G. I /Medical Due to (or as a consequer e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Records, Completed by Hypertension, Hypothyroidism, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Fibrilation, Dementic page 2 s autopsy performed? certificate of Vital 1 □Yes 2 JANO To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ ₩6 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY, 23, 2010 danah MID RES.001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHDIS HOSPITAL , SARRAFI 3001, South Hanover Street, Balkmone, MD, HARBOR 31. Date filed (Month, Day, Year) 32. Registrar's Signatur MAY 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Amend Items 14,15 per fh,g904,06/07/2010dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ROBERT ANTHONY GRYKEN 24, 2010 15:02 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ▼M 2 □ F 62 **Director** 27, 1947 <u>218-46-2076</u> Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
Ith and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f shoy traumatic event, the "ledical Exercity in court by nother of 1 ☐ Yes 2 ₹ No Director <u>Perry Hall</u> Maryland | Baltimore County 10e. Street and Number 10g. Citizen of What Country? **USA** 9003 Perryvale Road 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married White GRYKEN, KOBERT Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Assembly Line Coordinator Auto Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Sigmund Edna <u>Winter</u> Gryken Crouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 9003 Perryvale Road,, Baltimore, Maryland 21236 Dorothea C. Gryken (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 6/3/2010 Owings Mills, Maryland 21. Signature of Puneral Service Ocerisee

Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 hour Immediate Cause (Final **Physician** Acute right ventricular failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 days Bilateral pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. detached 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Left lower lobe squamous carcinoma Yes 2 No 3 Probably 4 Unknown , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1∑Yes 2 □ No certificate 1 ☐Yes 2 ☐No Division of Vital e Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) May 26, 2010 D38352

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schwartz,

6701 N Charles Street, Baltimore, Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician nau 50P 2010 Gatling 8 Veronica /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore Saint Agnes Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ F Director 60 215-52-4692 03 03 50 MD Usual Residence of Deceden filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State d other than "natural", or items 23a or 28a-f showers, the Medical Examinating at 28a-f shov 1 ☐ Yes 2 No Directo Catonsville Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21228 by Funeral 6215 Ethel Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event. Insulate. Day Care Provider Home 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary White Fred Woods 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Afton Street, Temple Hills, Md 20748 Preston Gatling-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/25/2010 Woodlawn, Md 21 Signature of Funeral Servi Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia u use (Final disease u ndition resulting ir death) **Physician** Encephalopathy Dru AnoxII /Medical Due to (or as a consequence of): Examiner Examiner Dun to (or as a nonsequence of) if any, Isauing to Immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE. yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 □ Yes 2 1 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P23612

29d. Date signed (Month, Day, Year)

May 18, 2010

Ö ₫. Vital ð

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Medical

(Check only one)

29b. Signature and title of certifier,

DAdwean, MD

9005 Caton Avenue, Battimore, MD 21229 ADMIKARI, DURGA DHOT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 18ª 2010 **CAROLYN** DAWSON GOODIN 10:35 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel 68 S. Paula Street Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Country) Wash., DC Days Hours Min Sept I Months Year 4 4 Yrs. 231-58-4780 65 Director Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 💢 o MD Anne Arundel Laurel 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20724 68 S. Paula Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married ☐ Yes 2 XXIo Saltimore, Maryland 21215-0036 1 Yes 2 XXIo Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 XX ivorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Accountant Property Management permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatical. traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Richard Dawson Josephine Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ersaline Hammett sister 236 Chesapeake Avenue Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 XX remation 3 Removal from State W. 5/22/2010 Arundel Crematory Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Solvida Lipensee 22 Name and Address of Facility Donald Son Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ty one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between shock, or heart failure. List or Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cardio Vascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leaving commodate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for sels done aquente of. Hospital or Attending Physician: The law lequires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown heen signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 🛣 nknown . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s After this certificate has autopsv performed? Yes 2 death? 1 Yes 2 X e B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XX Other: 5 Residence 6 Other (Specify) 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home |유 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred on.
s after deau.
ral Director: After 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours a Medical 1214 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 May 20, 2010 IDV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20708 Syed A. Sadiq, 14333 Laurel Bowie Road, Suite 208 Laurel, Maryland 31. Date filed (Month, Day, Year) 32. Registra Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 6 99000 5'.56 AM MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL GLEN BURNIE ANNE ARUNDE! LENTER Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-42-7536 1 X M 2 □ F Months Hours Min. 3(Mg)th, 129,448 **Director** Usual Residence of Decedent works permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Upton Road 21060 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) , WILLIAM Postal Worker Mail Delivery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William G. Hagood Sr. Mildren M. Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Upton Road Glen Burnie MD 21060 Shirley A. Hagood/wife HAGOOD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Crestlawn Cemetery 5/28/2010 Marriottsville, MD 4 Donation 5 Othe 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 21. Signatur M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SUDSIS Ph sician/ disease or condition resulting in death) Medical Due to for as a consequence of) Examine Clostridium difficile colitis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury metastetic escophage. Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Dav Year Yes 1 Yes 2 L 9 Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lesion to T-7. 1 Yes 2 No 3 Probably 4 Unknown روي ان 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed ? 1 Yes 2 No Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 2 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Certifying Nurse Prac 29b. Signature a DO0224

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year,

26 2010

ACOBS

mp

Glen Brrnie, MD 2106

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner ation of Death County of Deat Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 💢 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If tier 27 is named other than "natural", or items 23a or 28a-f show minoriant: If tier 27 is named other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director a 1 Yes 2 No 10e. Street and Number 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black Wh ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) bmestic nday (0-12) College (1-4 or 5+) Be ပ 19b. Mailing Address (Street and Number or Ru Ud 206 Baltimore, 20b. Place of Disposition (Name of cemetery, premator) or other 20a. Method of Disposition permit. Page 1 a Department of I-1 Burial 2 Cremation 3 Removal from State nation 5 Other (Specify) 21. Signatu wart 1. The r the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Betw Donset and Death mediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death Unknown ed by the detached 9 Unknown P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy death? 2 1 Yes Yes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 D N မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Death 28c. Injury at work? 1 ☐ Yes 27. Mann 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 112009 rson who completed cause of death (Item 23a) (Type, Print) V 140 32. Registrar's State

Registrar
DHMH 17 Rev 7/2009

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		For State Registrar	State of	of Ma	arylan	•		nt of H		and M	1ental Hy	gien	0	010	1645
Physician Medica	_	1. Decedent's Name (First, Midd MARVIN	lle, Last) HURST								2. Date of De Month May	eath	Day 2,	Žear 2010	3. Time of Death 4:05 a. M
Examine	er	4a. Facilify Name (if not institution 9790 Washingto 5. Social Security Number	n Blvd.		(In yrs. la	ast birthday)	I If Unde	aure]	If Under	24 Hrs.	8. Date of Bi	rth	tc. County HOW	ard 9. Birthpl	ace (State or Foreigr
Director	. 1	240-01-1278 Usual Residence of Decedent 10a. State 10b. Count	1		93 10c. City	Yrs. y, Town or Loo	Months	Days	Hours	Min.	oct 2	ay, Year	916	Countr	NC
fter d	by Funeral	MD Howa 10e. Street and Number 9790 Washingto 11. Marital Status 1 Never Married 2 XXM	n Blvd. 12. Was Dece Armed Fo	rces?	ver in U.S	If	Vas Dece Yes, spe	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	τ	J . S . A	e - America ck, White, et	n Indian,
d within 72 hours a lygiene. ther than "natural ant, the Medical Ex	Be Completed	(Specify only high Elementary/Seconday (0-12) Grade 10	ent's Education nest grade completed, College (1	ates.	+)	16a. Deced (Give k	ent's Usu and of wo NOT us	al Occupa	ation uring most Ler			Ar	Kind of B	usiness Indu	
nould be filed and Mental H marked ot Imatic ever	To B	17. Father's Name (First, Middle, Andrew C. Hurs 19a. Informant's Name/Relation	t			19b. Mailin	a Addres	s (Street a	Tem	pie (e (First, Middle, Coble I Route Numbe				nde)
Page 1 and 2 shent of Health a nrt: If item 27 is nrt: If or other trains		Gary P. Hurst 20a. Method of Disposition 1XXBurial 2 Cremation 4 Donation 5 Other		State	C	24724 lace of Disposemetery, cremedowrid	New	Post	Road	d S	t. Mich Date /2010	nael 20c.	S, M.		663-2308 vn, State
permit. F Departm Importa any inju		21. Signature of Funeral Service		/ M	0077	22	Name a Dona	nd Address	s of Facility	eral	Home, e Lauı	P. F	۸.		20707
Physician/ Medical		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	sta Sta	ge B	n. Do not ente			g, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death YYS
ate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to	or as a	y Ar	ence of): tery D ence of):	isea	se							yrs
ficate be e g physicia as the buri	Nedical		d. Peri	phe	ral	Vascul	ar D	iseas	se					y j	rs
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completed filled in by the funeral director, page 2 should be detached for use as the completed filled in the funeral director.	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, out 1	Birth 2 nant at	☐ Feta	Ideath 3	Ectopic Other (s	pregnancy pecify)	У					te of deliver onth E	y Day Year
requires that been signed the hould be deti	eted by P	Part II. Other significant condit Pacemaker, Mi					nderlying	cause give	en in Part I	•	1 🗆	Yes	2 □ No	3 🗌 Proba	cause of death?
an: The law tificate has b		Gastritis 25. Was case referred to medica	1					26. Pla	ce of Deat	h (Check	1 🗌 Yes	psy ormed?	F		sy findings available pletion of cause of
nding Physiciath. ith. After this cere funeral directory.	의	examiner? 1 Yes 2 XXo 27. Manner of Death 1 Avatural 5 Pend 2 Accident Inves	28a. Date	_	/	ER/Outpatien 28b. Time of injury		OA Other 28c. Injury work?	r: 4□ Nu at	rsing Hor	me 5 Resi				
vital or Attendir urs after death. ral Director: Af illed in by the fu	al Certificate:	3 Suicide 6 Could 4 Homicide deter	d not be mined 28e. Place buildi	ng, etc.	(Specify)						28f. Location (City or Tov	vn, Sta	te)		
To the Hosp within 24 ho To the Fune completed fi	Medical	(Check 2 \(\subseteq \text{ Medical} \)	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of exa	amination est of my	knowledge, d	eath occu	my opinior	time, date	curred at	the time, date a	and plac ne cause	ce, and due e(s) and ma	e to the caus	e(s) and manner state ed.
6		30. Name and address of persor		-	ath (Item			D547						, 2010)
State Registrar	1	Allen Reilly, 31. Date filed (Month, Day, Year)		egistr	's Signat	ure	oss	III 85	, Bal	timo:	re, Mar	ryla	nd :	21228	

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State	State of M	arylan					and M	lental Hy	/giene	001/		- 1
			Registrar 1. Decedent's Name (First, Middle, Last)	·	Cer	tificate	of D	eath	-	0 D++ - + D	Reg. No.	411	<u> </u>	145
	Physicia		Albert Henry Hoga								2. Date of Do Month May	25 ^{Day}	20 ^{Yea} r	3. Time of 5:45	f Death AM
	Medic Examin		4a. Facility Name (if not institution, give s				4b. City,	Town, or	Location o		Tiay		ounty of Death	10.40	
			Gilchrist Center		ce Ca	are	Tows	on				Bal	timore		
	Funeral		5. Social Security Number 6. Sec	X M 2 □ F 7. Ag		st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9. Birth Cour	place (State o	_
	Director		220-07-1697 Usual Residence of Decedent		88	TIS.					Aug. 12	2, Year) 92.	1	""Mary	land
	land show dat	호	10a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside Ci	ty Limits
	Mary 28a-f otifie	irec	MD Baltimor	e	Tows	on								1 🗆 Yes	2 X No
	th the 3a or tbe n	Funeral Director	10e. Street and Number	#010			10f. Zip						of What Cou	ntry?	
	ath wi	uner	409 Virginia Aven	ue #319 12. Was Decedent 8	Ever In I.I.S.	12 1/		286	pania Oria	in? (Cna	oif (Voe or No	USA			
ထ	er dea or ite		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	No.	If				, Puerto F	cify Yes or No Rican, etc.)		Race - Americ Black, White,	etc.	
<u></u>	ırs aft ıral", IExal	edt	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2	No 🛣 No	Specify:			Spe	_{ecify:} whi	te	
<u>2</u> -0	72 hou "nate edica	Completed by	15. Decedent's Ed (Specify only highest grad			16a. Deced (Give k	and of work	done du		of workin	ng	16b. Kind	of Business In	dustry	
12	ithin 7 ene. r than	Con	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	0wner	O NOT use	retired)				Shoot	Metal	Contr	20+04
ر م	led w Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)			Owner			18. Mothe	r's Name	(First, Middle			COILLY	actor
<u>la</u> n	d be fi dental irked tic ev	To	Joseph Hogarth								Gette		,		
ar	should and Iv is ma		19a. Informant's Name/Relationship (Тур	e, Print)			g Address	(Street ar	nd Number	r or Rural	Route Numb	er, City or Tov	vn, State, Zip	Code)	
ა"	and 2 lealth sm 27 her tr		Lorinda Sullivan	/ daughte		14003			e NE;	Bot	hell,		011		
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔼 Burial 2 🗆 Cyemation 3 🗀 I	Removal from State	ce	ace of Dispos emetery, crem	atory or ot	her place	· :		ate		ion - City or To		
를	nit. Pa artmer ortani injury		4 ☐ Donation 5 ☐ Other (Specify,		Dula	ney Val	ley Men				2010	Timon	ium, M		
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			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ication that caused	the death								7000	Approximate	e
~ .	Physician/	0 1	Immediate Cause (Final disease or condition	Desc le	2/01	10	Dis	200	=				,	Onset and D	
	Medical Examiner		resulting in death)	le to (or as	a conseque		Ule	7/200						1	
		er	Sequentially list conditions,	Due to (or as	a consodu	ance off:									
	hed nsit	Examiner	if any, leading to immediate Cause (Disease or iinjury	Due to lot as t	a conseque	erice oi).									
	execur in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):									
00	or Attending Physician: The law requires that the death certificate be executed ifter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d											
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Box (ath ce attend for us	cian	in the past 12 months?	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	death 3 🗌	Ectopic p					23d	. Date of deliver Month	*	⁄ear
, M	he dea y the a	hysid	1 🗌 Yes 2 🗌 No 9 🗍 Unknown	9 Unknown	t time of de	Saul J 🗆	Other (spe								
о. О	that t ned b e deta	by P	Part II. Other significant conditions con	- 1		Ilting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use o	contribute to th	ne cause of de	eath?
ds,	quires en sig suld b	ted	Caronary anny	y disco	ite,	COP	V				1 🗆	Yes 2 7	No 3 🗆 Prol	oably 4 🗌 l	Jnknown
CO	aw rei as be	Completed	·								24a. Was		4b. Were auto	osy findings a	vailable ause of
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<u>ra</u>	sician certifi rector	Be o	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:				Othor	ce of Death		· ·	in a		1	
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u O	ath. r: Afte	icat	1/☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	r, Year)	injury	М	work?	′es 2 🗆 1			,,			
Division of Vital Records,	or Atter ter de irecto	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	iry - At hon	ne, farm, stre	et, factory,	office		2	8f. Location (ımber or Rural	Route Numb	er,
ā	oital o									9					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1	er: On the basis of e	xamination :	and/or investi	gation, in m	iv opinion	 death occ 	curred at t	he time, date a	and place, and	due to the car	use(s) and mar	ner stated
	To the within To the comp	≥	29b. Signature and title of certifier	Fractioner, to the	best of my	Kilowiedge, di		License r	-	and place	, and due to tr		gned (Month, I		
			Algula	VS			1	125	330	3		MAY	4 25	201	0
			30. Name and address of person who co	mpleted cause of de	eath (Item 2	23a) (Type, Pr	rint)	g A		1	108 2	7 - 5		1	2
			31. Date filed (Month, Day, Year)	32. Fegistra	ar's Signatu	Iro P	670	06 1	0.0	nas	les à	Pr 7	one	v in	
	Stat Registra	-	MAY 26 20	10 Jener	M J	1. 4	arke								

		For State of Marylar	•			lental Hyg	jiene	10 161 50
		Registrar 1. Decedent's Name (First, Middle, Last)	<u> </u>	rtificate of De	eatn		Reg. No.	111111111111111111111111111111111111111
Physici		CONSTANCE C. HOFFMAN				2. Date of Dear Month MAY		3. Time of Death 010 6:38 P M
Med Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County of	
and the same		Holy Cross Hospital		Silver			Montg	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
Director		578-62-2399 1 □ M 2 🖾 F 72	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV • I	Year 1937	Country) DC
W		Usual Residence of Decedent						
/land f shc	햐	10a. State 10b. County 10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
Man 28a- otifie	Director	DC W	ashingt	on				1 🔀 Yes 2 □ No
a or	100	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	at Country?
s 23 nust	Funeral	3727 Bangor St. SE		20020			USA	
deatl item	Ξ	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No-		American Indian,
36 after	b	1 Never Married 2 X Married 1 Yes 2 No		I ☐ Yes 2 🖾 No				White, etc.
Ours tural	Completed	3 🗆 Widowed 4 🗆 Divorced Year or Dates.					Specify:	Black
15-) ge	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupati kind of work done dur		ng	16b. Kind of Busi	ness Industry
thar than be N	l S	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired) acher			or Public	c Schools
Hygieint, t	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name			DCHOO15
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	은	Robert Cooper			Sadie M		naideri Surriame)	
ould Mar mar mar		19a. Informant's Name/Relationship (Type, Print)	10b Mailir	ng Address (Street and	d Number or Pura	Pauta Number	City or Town Star	to Zin Cada)
Z sh Ith an 27 is	1	Gilbert L. Hoffman - Husband	1.1	Bangor St			on, DC 20	
Te, and Head Head Head		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of	<u> </u>		20c. Location - C	
age ant of nt: If		Tablana 2 di Grandadir d' di Ticinova nom diate	-	natory or other place)				
Itir nit. P artme ortar injur		21. Signature of une al Service Licensee		lemorial Co				
Dep Depris		Voluntering Cula	21 4º	Nameard Address 108 Suitlar	rumeral . nd Rd.	Home of Suitland	Maryland 1, MD. 20	1)746
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Physician	,	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	_1_					Interval Between Onset and Death
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876 ificate ig ph	¥ed	IE FEMALE.			-		1	
certi endin	au/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnat 1		Ectopic pregnancy			23d. Date	of delivery
30) death le att	Sici	1 Yes 2 No 4 Pregnant at time of		Other (specify)	_		Month	n Day Year
P.O. Box 687 that the death certificated by the attending parted for use as	Physician/Me	9 Li Orikriown				T		
S that		Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause given	n în Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
ds, quire en sij	ē					1 □ Ye	es 2 🖾 No 3	☐ Probably 4 ☐ Unknown
aw reas be	Completed by					24a. Was ar autops	24b. We	re autopsy findings available or to completion of cause of
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rtiffica	Be (25. Was case referred to medical examiner?		26. Place	e of Death (Check		22 110	3.100 2.2110
ysic nysic nis ce dire	짇	1 Yes 2 No Hospital:	ER/Outpatien	t 3 DOA Other:	4 Nursing Hor	ne 5 🗌 Reside	nce 6 Other	Specify)
of ng Pl fter th		27. Manner of Death 1	28b. Time of injury	28c. Injury at work?	t 2	8d. Describe ho	w injury occurred	
ion tendi eath. or: A	ific	2 Accident Investigation 3 Suicide 6 Could not be			es 2 🗆 No			
Division of Vital Records, as or Attending Physician: The law requires is after death. In Director, After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	4 Homicide determined 28e. Place of Injury - At hubuilding, etc. (Specification of the building)		eet, factory, office	2	8f. Location (Str		or Rural Route Number,
Dital ours a stral Dilled i								
Hos 24 hc Fune	Medical	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination	n and/or invest	igation, in my opinion.	death occurred at:	he time date and	diplace and due to	the cause(s) and manner stated
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 Cartifying Nurse Prentioner T. the best of a 29b. Signature and title of certifier	y teroWkidge; d	29c. License no			educe(c) and mann 9d. Date signed (A	
r s ř ō		Sun		D00563			5/19/201	*
		30. Name and address of person who completed cause of death (iten	n 23a) /Tvne 📮				J/ 1 J/ 201	
6 V		Mary E. Wright, MD 1580 Fores		•	ver Spri	ng, MD.		
Sta	ite	31. Date filed (Month, Day, Year) 32. Degistrar's Signa	ature			J,		
Registi		MAY 2 6 2010 Dama	B. Spa	ake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23 Physician/ William Hauer David 2010 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dundalk 1821 Walnut Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Month, Day, Year) 1ne 25, 1937 1 🕅 M 2 🗆 F Hours 220-36-4428 Director June Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 21222 USA 1821 Walnut Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 🗌 Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Plastics Machinist <u>12 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Dorothy Raidy William James Hauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau P.O. Box 173, Glen Arm, Maryland 21057 Michael Hauer son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 28, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery: Baltimore, Maryland 2010 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P. A 7110 Sollers Point Road, Dundalk, Md. 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to fir as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for sels consequence of attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No the 9 Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 🗌 Yeş ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 124 hours after death. injury work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending n 24 hours after user he Funeral Director: After managed filled in by the fur 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier 29c. License number 22150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

1 🗆 Yes 2 🗓 No

MAryland

White

6:44 P M

State Registrar

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 22 pay 2010 6:10 p M SHIRLEY MAE INGRAHAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 12330 Scaggsville Road Fulton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country)
 TTA 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖁 🛣 July Pay, Year 27 VA 579-28-8293 82 Director Usual Residence of Decedent artment of Health and Mental Hygiene. ortaint If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Fulton 1 Yes XX No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 12330 Scaggsville Road 20759 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ※Xo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 KM Arried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXIo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Howard County Elementary/Seconday (0-12) Grade 12 College (1-4 or 5+) Guidance Secretary Public Schools Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Addie Harkey William Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7653 Woodville Road Mt. Airy, Maryland Scott W. Ingraham 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) Louis Cemetery 5/28/2010 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
Donaldson Funeral Home, Maryland 21. Signature of Euneral Service Licensee M00770 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnly one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 month 1 ☐ Yes 2 [X]Ko g ☐ Unknown Month Day Year Pregnant at time of death been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2XX No 24a, Was an autopsy performed? Yes 2 A cate has l this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Hesidence 6 Other (Specify) 1 ☐ Yes 2 🗓 💢 ၣ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 XXatural 5 Pending 1 Yes 2 No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 May 24, 2010 m D41139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, Maryland 10710 Charter Drive, Suite G-020 Clement Knight 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Albert Μ. Jackson 8:00 A 25^{pay} 20 ໃຕ້ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Stella Maris Baltimore Timonium Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 414-18-1562 Davs 1 🛛 M 2 🗌 F Hours Min June 6 86 Tennessee °1°923 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director Baltimore Maryland Timonium 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2525 PotSpring Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1

X Yes 2

No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married X Yes Yes, Give Year or Dates. 1944-46 1 ☐ Yes 2 X No Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Bert Smith Page 1 and 2 should be Albert M. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4728 Leyden Way Ellicott City, Maryland 21 Annette Morrison / Daughter 21042 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John Cemetery 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/28/2010 Sweet Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. Signature of Fundamental Signature of Fundamental Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CIRRHOSIS OF THE LIVER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dub to for as a consequence of: attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death?
1 ☐ Yes 2 ☐ No Director: After this certificate To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours after To the Funeral Dire City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date sighed (Month, Day, Year, 2010 30. Name an of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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2010

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** S Kahl May 24 2010 1:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Parkville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours Min 220 34 6744 Director 79 March 14 1931 Perry Hall. Md. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Director Maryland Baltimore 1 ☐ Yes 2√☐ No Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3821 Perry Hall Rd. 21128 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2XX Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 🗶 No ъ Specify: Specify: White 3 Widowed 4 Divorced than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Self Employed Farmer marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F John Edward Kahl Theresia Noppenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau Selma Kahl (Wife) 3821 Perry Hall Road Perry Hall, Maryland 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory Inc. May 25 2010 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc ignature of Funeral Service Dicensee 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of or complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer each line nset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, No. 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 かいろい 2010 30. Name and add erson who completed cause of death (Item 23a) (Type, Print) 8400 Walther randur 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benson

Registrar's Signature

3320

MO

Mina

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:30 hmet 2010 Kora Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death NorthWest Randallstown Hospital Center Baltimore Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 😾 M 2 🗆 F Month Min Director 2-02-0961 March 10,1944 Cyprus Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director MD Baltimore Windsor Mill 1 🗌 Yes 2 🖾 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be i Funeral 1922 Greengage Road 21244 Cyprus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Maryland 21215-0036 If Yes, Give Year or Dates Specify: Caucasian Completed 3 Widowed 4 Divorced M-dical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Cashier Gas Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F
77 is marked of ပ Kazim Kora 1 and 2 should be of Health and Menta Katriye Mustafa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hatice Kora/ Wife Important: If item 27 any injury or other tra 1922 Greengage Rd. Windsor Mill, Maryland 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Nicosia Cemetery 4 Donation 5 Other (Specify) 6/2/2010 Nicosia, Cyprus Signature of June al Service Licensee ²²Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, MD 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ efractory disease or condition Medical resulting in death) Examiner corona Sequentially list conditions iner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. trans and that initiated events resulting in death) Last Due to (or as a consequence of): as been signed by the attending physician as should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic obstructive pulmonary disease, 1 Yes 2 No 3 Probably 4 Unknown Acute respiratory failure, Acinetobacter pneumonia Prosthetic mitral valve. Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 028462 21 2010 May

DHMH 17 Rev 7/2009

Registrar

Northwest

Maryland

Randalistown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ton

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31. Date filed (Month

		_	For State	State of I	Marylan	-	artment <i>tificate</i>			ind Me	-	-	2010	161.59
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncate	OI DE	auı		2. Date of Dea	Reg. No. (2010	3. Time of Death
	Physicia			Klein							Month 5	Day 2.1	Year 2 01 0	2:45 P M
	Medic Examin		4a. Facility Name (if not institution,)		4b. City, To	own, or Lo	ocation of	Death		T.,	County of Death	
ار س			NorthWest Hospital					allst					ltimore	
	Funeral Director		5. Social Security Number 214-24-2453	6. Sex 1 M 2 xx F	Age (In yrs. Ia	as <i>t birthd</i> ay) Yrs.	If Under 1 Months		Hours	Min.	B. Date of Birt (Month, Date 11 v 27	y, Year)	9. Birth Co <i>ur</i> Maryl:	place (State or Foreign htry) and
	MC .		Usual Residence of Decedent									1,74,7		
	rylanc I-f sho ied at	ctor	10a. State 10b. County	n/a		y, Town or Lo L timore	cation							10d. Inside City Limits 1 Yes 2 □ No
	ne Ma or 28a notif	Dire	10e. Street and Number				10f. Zip (Code				10a. Citiz	en of What Cou	
	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	220 East Barney Str	reet				21230				U.S	.A.	,
	death items ner m	Fun	11. Marital Status	12. Was Deceder Armed Forces		S. 13. \	Was Decede f Yes, specif	nt of Hisp v Cuban,	anic Origi Mexican,	in? (Specif Puerto Ric	y Yes or No-	1.	4. Race - Americ Black, White,	
36	after after xamir	d by	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	ied 1 Tes 2 If Yes, Give	X No		1 ☐ Yes 2					s	pecify: Whit	
0	hours hatura ical E	Completed	15. Deceden	Year or Dates t's Education			dent's Usual					16b. Kin	d of Business In	dustry
215	in 72 e. nan "r	dwc	(Specify only higher Elementary/Seconday (0-12)	st grade completed) College (1-4 c	or 5+)	life. D	kind of work O NOT use i		ring most o	of working			-1	
2	d with lygien ther th	Be C	8	0		Homem	aker						maker	
land	2 should be filed tth and Mental Hy 27 is marked oth traumatic event	F B	17. Father's Name (First, Middle, L Benjamin Williams	ast)							First, Middle, hnabel	Maiden Su	urname)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minorant: If item 27 is marked other than "natural", or items 25a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Delores Klein dat	ip (Type, Print) ighter							Route Numbe ore, Mai		own, State, Zip 21230	Code)
re,	1 and of Heali fitem 2		20a. Method of Disposition			Place of Dispo emetery, cren	natory or oth	ner place)		Da	I		ation - City or To	
Ē	Page ment o ant: If ury or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		te Crow	vnsville	Vetera	ins Ce	m. Ma	ay 26,	2010	Crown	sville, M	aryland
Balt	permit. Page Department (Important; If any injury or once.		21. Signature of Furieral Servine	(NACO)									uneral Ho nd 21230	me P.A.
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cause	sed the deat									Approximate Interval Between
ę	hysician/		Immediate Cause (Final disease or condition	Metast	atic Li	ing (a)	ner							Onset and Death
	Medical Examiner		resulting in death)	Due to (or a	as a consequ	uend of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	defice off.								
	ecuted and transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or s	as a consequ	ience off:								
	vate be executed physician and the burial-transit	dicalE	resulting in death) Last	Due to (or a	as a consequ	derice oij.								
3760	ficate g phys as the	ledi		d										
86 ×	h certi tendin r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 moyths?	23c. If yes, outcor	h 2 🗌 Feta	al death 3	Ectopic pr	egnancy				2	3d. Date of deliv	
Bo	e deat the at hed fo	Completed by Physician/Me	1 Yes 2 No	4 ☐ Pregnan 9 ☐ Unknow		death 5	Other (spe	cify)					Month	Day Year
Ö	hat the ed by detac	y Ph	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the u	ınderlying ca	use giver	in Part I.		23e. Did to	obacco us	e contribute to t	he cause of death?
S,	uires t n sign líd be	q pa								_	10	Yes 2 □	No 3 Pro	bably 4 \square Unknown
Š	iw req is bee 2 shoi	plet									24a. Was			psy findings available empletion of cause of
Rec	The la ate ha page	Som									perfo	rmed? 2 No	death?	. /
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:						n (Check o	, , ,			in hal nice
<u>`</u>	Physi this c	은	1 Yes 2 No 27. Manger of Death	1 ☐ Inp		ER/Outpatier 28b. Time of		Other: c. Injury a			e 5 🗆 Resid			int hospice
0 00	ending eath. rr. After ne funer	icate	1 Natural 5 ☐ Pendin 2 ☐ AccidentInvestig	g (Month, i jation	Day, Year)	injury	M	work?	 es 2 □ 1		a. Describe r	iow injury (occurred	
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could l 4 ☐ Homicide determ	ined 28e. Place of	Inju r y - At ho etc. <i>(Specify</i>		eet, factory,	office		28	f. Location (S City or Tow		Number or Rura	l Route Number,
	e Hospit 24 hour e Funera eleted filk	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis of Nurse Practioner: To t	of examination	n and/or inves	tigation, in m	y opinion,	death occ	curred at th	e time, date a	and place, a	and due to the ca	use(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifier	0										
			30. Name and address of person w	who completed cause o	f death (Item	23a) (Type, F	Print) Av. S.	-235	Bo	1/nm	ore, n	10.	signed (Month, 121/10)	1.
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa			- /					/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Year 1:10 AM A 201 County of Death Town, or Location of Death

Heil

If Under 1 Year

Days

Months

BURNIE

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24 Hrs Min.

Hours

8. Date of Birth (Month, Day, May 19

Year) 1933

Birthplace (State or Foreign Country)

1 Home, P.A 1122

2010

MD.2016

GA

1 □ M 2 🔀 F

Hospital

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

enitical

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kalpesh Patel Bultimone Wushington

2.☑No

29b. Signature and title of pertifier

pesh

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

Pate

1∐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

7. Age (In yrs

Physician /Medical Examiner

213-30-3786

Funeral Director

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Experiment or other traumatic event, Ite Modical Experiment units to profit of all

LEIKAM, GENEVIEVE

Physician /Medical Examiner

Examiner

Completed by Physician/Medical Be Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Usual Residence of	Decedent			,							
	10a. State	10b. County		10c. City,	Town or Loca	ation					10d. Inside City Limits	
ctor	Maryland	Anne	Arundel				Gle	en Burnie			1 ☐ Yes 2 ☐ No	
)ire	10e. Street and Nun	nber				10f. Zip Code			10g. C	itizen of What C	ountry?	
ral	7836 She	ellye Roa	ad				210	060		U	SA	
Fune	11. Marital Status	ed 2⊠ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13. W	as Decedent of F Yes, specify Cub	lispanic (an, Mexic	Origin? (Specify Yes or I an, Puerto Rican, etc.)	No-	14. Race - Am Black, Whi		
d by	3 ☐ Widowed	_	If Yes, Give Year or Dates:		11	□Yes 2☑No	Speci.	fy:		Specify:	White	
Be Completed by Funeral Director		15. Decedent's E	rade completed)		(Give kind of work done during most of working				Kind of Business	s/Industry		
mo:	Elementary/Secon	ndary (0-12)	College (1-4or 5	i+)		Hou	sehold					
3e C	17. Father's Name (First, Middle, Las	st)			n Surname)						
ဥ	Willian	n Cha	rles Wol	Lfe								
11/	19a. Informant's Name/Relationship (Type. Print) William F. Leikam (spouse) 19b. Mailing Address (Street and Number 7836 Shellye Road,						and Nun	nber or Rural Route Nun	ber, City	or Town, State,	Zip Code)	
							d, Glen Bur	nie,	MD 2106	50		
	20a. Method of Disp		☐ Removal from State	20b. Pla	ce of Disposi netery, crema	tion (Name of atory or other plac	ce)	May Date 27	20c. L	ocation - City or	r Town, State	
		5 Other (Spec		Metr							re, Maryland	
2.0	21. Signature of Funeral Service (ice) ee 22. Name and Address of Facility Stallings Funer 3111 Mountain Road, Pasadena, MD										cal Home, P. 21122	
	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.										Approximate Interval Between Onset and Death	
	Immediate Cause (disease or condition resulting in death)	Final \	a		mon	ia					Oriset and Death	
			Due to (or as	a conseque	nce of):	LO H	205	+ 6.11.	h 0			
ner	Sequentially list con	nditions,	b. Due to (or as	a our seque	nce of):	VC IIE	- NVL	Farra	7.5			
kami	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		C	Cor	- Pu	lmona	10	t failu				
a E	100amig iii 00ami 2		Due to (or as	a conseque	nce of):							
gic	****											
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3 🗌 l	Ectopic pregnand Other <i>(specify)</i> _	у			23d. Date of de Month	elivery Day Year	
Dy P	Part II. Other signifi	cant conditions	contributing to death be	ut not resulti	ulting in the underlying cause given in Part I. 23e. Did tobacco use contril						to the cause of death?	
etec												
Comple								24a. Wa au pe 1 ∐Yes	topsy formed?	prior to death?	utopsy findings available completion of cause of s 2 2 100	
Be	25. Was case referrexaminer?			ce of Death (Check only	one)							

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐Yes 2 ☐ No

Medical Center,

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Care

pluy sician

State Registrar

DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 ner fh 9904 6-4-10 yr #7, 19a, b. per FH, G904, 6/9/2010, WS State of Maryland Department of Health and Mental Hygiene AMEND ITEM#2perPHYS G205 7 Death 2010, WS , #3 646 State Registrar Reg. No. 2. Date of Death 5 /20/2010 1. Decedent's Name (First, Middle, Last) Time of Death Month ___ Physician/ Mack Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 🗆 F 219-66-6046 MD Director 52 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location e filed within 72 hours after death with the Maryland aţ Director 3a or 28a-f sh be notified 1 Yes 2 No MD Baltimore na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral l W. Conway Street U S "natural", or items 23. Α 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: Black 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry per it. Page 1 and 2 should re filed within 72 h
Derartment of Health and Mental Hygiene.
Important: If item 27 is married other than "na any injury or other traumatic event, the Mental Roll." na (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson Mack, Sr Jessie Mae Barnes 21217 MD 19a. Informant's Name/Relationship *Gyope Printly* **Sister**Gloria Mack—Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2028 Mt Royal Terrace Apt 504 Balto, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of per it. Page 1 a
Derartment of F
Important: If ite
any injury or ot cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Trinity Cemetery 5-28-2010 Balto, MD 4 Donation 5 Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebra Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a g 🗌 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s nas performed? Yes 2 No 1 Yes 2 No this certificate Hospital or Attending Physician; 25. Was case referred to medical director, 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ဂ္ 🕍 Inpatient 2 🗆 ER/Outpatient 3 🗆 DCA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No М Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 24432 ZI 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimere, Suite 1210 21201 South Greene 32. Registra's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Month 2036 pM Mogg John T Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Baltimore FRANKLIN Square Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Days Hours Min. Jahuar V^a18^a1928 217 22 3047 82 Overled, Maryland Yrs. Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Maryland Baltimore Baltimore County 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4415 Vale Drive 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married X Yes Mog g ∨onn Maryland 21215-0036 2 No If Yes, Give Year or Dates. WW II 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Bethlehem Steel Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Smith George Mogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen R McLaughlin 10521 Gorman Road Laurel, Md. 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery May 24 2010 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licenses Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Acute Coronary undrom disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hypercholesterolemia Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv page performed' 2 🗌 No 1 🔲 Yes Yes 2 🔄 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ၉ 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Suicide Investigation 6 Could not be

Division of Vital within 24 hours after de

To the Funeral Directo

completed filled in by the

State

Registrar DHMH 17 Rev 7/2009

Medical

4 Homicide

3

29b. Signature and title of certifier

30. Name and address of person

DR COURTR

31. Date filed (Month

29a. Certifier (Check

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Itam 23a) (Type, Print)

Registrar's Signatu

Me

6

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64393

FRANKLIN

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Sanare DR Ballo ind 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. \$19 per Fh G903 5/27/10 TT State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20**1**0 22:18P M 22 Florence Madison Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Reisterstown Future Care Cherrywood Madison 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 🗶 Hours 243-20-7212 Director 84 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2X No Baltimore Windsor Mill Florence 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7898 21244 Galloping Circle USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore School Elementary/Seconday (0-12) 12th Grade Engineer System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samue1 Florence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) 7898 Galloping Circle Windsor Mill, Page 1 and 2 Eugene Smith-Grandson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a, Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 05-28-10 Catonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) -purial-Physician/Medical attending physical for use as the b E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 1 \sum Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the respiration within 24 hours after death.

To the Funeral Director: After this standard filled in by the funeral Certificate: 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No 2 Accident Investigation 6 Could not be 3
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier completed cause of death (Item 234) (Type, Print) 30. Name and address of 21208 31. Date filed (Month.

DHMH 17 Rev 7/2009

State Registrar

		For State	State o	f Marylan	•	rtment d			Mental H		20	10	154	64
		Registrar 1. Decedent's Name (First, Middle, La	st)		061	uncate	or De	aur	2. Date of D	Reg. No).tm \	-	3. Time of	
Physicia		MILDRED THERESA	,						Month May	20 ^{Da}	ay 2	Year 2010	1925	Death M
Medic Examin		4a. Facility Name (if not institution, give				4b. City, Tox	wn, or Lo	ocation of Deat			. County			
,		Holy Cross Hospit	al			Silv	er S	Spring		1	Monto	gomer	Y	
Funeral Director		5. Social Security Number 6. 8	Gex I □ M 2 □ E	7. Age (In yrs. Ia 81	st birthday) Yrs.	If Under 1 Months D		f Under 24 Hrs Hours Min.		irth Day, Year) 4 , I	229	9. Birthpl Counti	ace (State or 'y) NY	Foreign
		Usual Residence of Decedent		01					pair. Z	4, 1.	727		1/1	
shov d at	호	10a. State 10b. County		10c. City	, Town or Loc	eation						10	d. Inside Cit	y Limits
Mary 28a-f otifie	Director	MD Montgo	mery	S	ilver	Spring	ſ						1 🗌 Yes	2 XX Vo
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r deat	/Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deced Armed For 1 \sum Yes	dent Ever in U.S				anic Origin? (S Mexican, Puerl	pecify Yes or No to Rican, etc.)	0-		e - America k, White, e		
s after al", c Exam	d by	3 XXWidowed 4 □ Divorced	If Yes, Give Year or Da	9	1	☐ Yes 2🛚	XNo	Specify:			Specify:	Wh	ite	
hours natur lical	Completed	15. Decedent's I	Education		16a. Deced	ent's Usual C	ccupation	on		16b. k	Kind of Bu	siness Ind	ustry	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show minortant: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last) John Gomes					- 1	8. Mother's Na Leonore	me (First, Middle	e, Maiden	Surname)		
d Mer d Mer mark matic	-	19a. Informant's Name/Relationship (Time Oriet							0"	~ 0			
2 sho th an 27 is trau		Lolita Davis		ughter					ural Route Numl . Apt.					MD
f Heal		20a. Method of Disposition	/ 44	20b. P	lace of Dispos	sition (Name	of	i i	Date			City or To		TID
ent of ent of nt: If		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Spec			emetery, cren Arund			ory 5/2	4/2010	Ode	entor	. Mai	ryland	
partm partm porta / injui		21. Signature of Euneral Service Licer							Home,			•	2	
an)		I CITY AN		M00770	3	13 Tal	bott	Avenu	e Laur	ei, n	Maryl	and	20707	
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cone cause on eac	aused the death	n. Do not ente	r the mode o	f dying,	such as cardia	or respiratory	arrest,	_		Approximate Interval Betv	
Physician/		Immediate Cause (Final disease or condition		psis									Onset and D	
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eath certifice attending p I for use as I	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna Birth 2 Feta		Ectopic pre	anancy				23d. Dat	e of delive	ry	
death	Physician/Me	in the past 12 months? 1 Yes 2 XXIo		nant at time of c		Other (spec				.	Moi	nth I	Day Y	ear
requires that the de been signed by the should be detached	Ph	g Unknown Part II. Other significant conditions			ulting in the u	nderlying cau	ise diven	in Part I	220 Did	Ltobacco	uno contr	ibuta ta the	e cause of de	ath?
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ysician: is certific director,	To Be	examiner?	Hospital:	Apatient 2 🗆	ER/Outpatien		Other:		Home 5 Re	aidanaa (2 D Otho	r (Cnapify)		
g Phy er this ieral c		27. Manner of Death	28a. Date		28b. Time of injury		Injury a		28d. Describe					_
ath. r: Aft	lical	1 Natural 5 Pending 2 Accident Investigation	on	II, Day, Tear)	Injury	М	work?	s 2 No						
r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place	of Injury - At ho		eet, factory, o	ffice		28f. Location City or To	(Street ar		r or Rural I	Route Numb	er,
ital o urs af ral Di lled ir	a C	3237												
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending plant or the Funeral Director. After this certificate has been signed by the attending plant or completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	29a. Certifier 1 X Sertifying Phy (Check 2 Medical Exam	niner: On the basi	is of examinatior	and/or invest	igation, in my	opinion,	death occurred	at the time, date	and place	e, and due	to the cau	se(s) and mar	ner stated.
ithin the orthe	Ž	only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practioner:	To the best of my	/ knowledge, c		at the ti		ace, and due to			nner as sta (Month, D		
FSFŐ		Tun	Noter	Min			3233					201		
101		30. Name and address of person who	completed cause	e of death (Item	23a) (Type, P		J _ J _	- 4		1 146	~1 42	, 201		
10.		Suresh K. Gupta	9801 Ge				220	Silv	er Spri	ng, N	4D 2	0902		
Stat		31. Date filed (Month, Day, Year)		egitrar's Signat		harda								
Registra	ar	MAY 2.6	OUT OF	2	10	Ann. Mar.	M							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 May аМ 7:30 Joseph Makowski Stanley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Marley Neck Health & Rehab. Center Glen Burnie Social Security Number 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Davs Hours Min. Dec 22 Year 1933 Pennsylvania Director 191-28-0388 76 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 255 Federalsburg 20724 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food 12th Ø Price Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vishnefaki Alogius Makowski Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wyoma I. Makowski/Wife 255 Federalsburg S. Laurel, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 5/24/2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A.)M01103 313 Talbott Avenue, Laurel, MD muol 23a. Part 1/ Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician Cardiac Arrythmia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 2 No detached 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive Completed 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. completed filled in by the t Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not fee Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct determine City or Town, State, Medical 1 Certifying Ply's can: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying June Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31, Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:45 a May 21, 2010 Helen S. Mills 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Edenwald Towson Tif Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 13, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □ F Maryland 213-14-8051 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 □Yes 2 TXNo Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 U.S.A. 800 Southerly Road #411 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√√No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schultz Jerscheid William Ε. Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10615 Topsfield Dr., Cockeysville, MD Nancy Franklin-niece 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 5/25/10 Timonium, MD 4 □ Donation 5 ☑ Other (Specify) entombment 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hypoxemia ALUTE disease or condition resulting in death) Due to (or as a consumuence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

Physician /Medical Examiner

physician and the burial-transit

attending p for use as

been signed by the sahould be detached f

certificate has be rector, page 2 s

r this certific ral director,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral!

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any highly or other traumatic event, the Madical Exercises once.

Baltimore, Maryland 21215-0036

the

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

> 3 Ectopic pregnancy 5 Other (specify)

Month

No

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tes 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

28d. Describe how injury occurred

Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

3 ☐ Probably 4 ☐ Unknown

Year

25. Was case referred to medical examiner? 2 1∐ Yes 27. Manner of Death Natural 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

CRNP

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title of certifier CRNP Schen

R154032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

800 Southerly Rd SUSAN 32. Redistrac's Signature 31. Date filed (Month, Day,

State Registrar Year)

and manner stated

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MITCHELL J THELMA 20 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HOSPITAL SECONAS AZTIMORE LTIMORE 8. Date of Birth (Month, Day, OCT . 10 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral Min. 1 □ M 2 □ F Months Hours ī̈́95<u>5</u> | Director 220 74 4000 54 N. Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County or 28a-f shown notified at 10a. State 10d. Inside City Limits Director n/a MD Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 ral", or items 23a or Examiner must be 21229 409 Edgewood St. Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes ※※ No Black, White, etc. þ 1 Never Married 2 Married Specify: USA 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event. The Manal once. Elementary/Seconday (0-12) College (1-4 or 5+) GED HOTEL Housekeeping Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lonnie Mitchell Hattie Mae Roval 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Atkinson(daughter) 409 Edgewood St. Balto, Md. 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

. Zion Cem. 1 XBurial 2 Cremation 3 Removal from State May 28,2010 Mt. Baltimore, Md. ☐ Donation 5 ☐ Other (Specify) unature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRADYCARDIC Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to GASTRIC CONTENTS attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IEUS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Month Dav Year Pregnant at time of death ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHOLECYSTE CTOM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown should SMALL BOWER 24b. Were autopsy findings available prior to completion of cause of death? OBSTR VETTON 24a. Was an s certificate has the director, page 2 s autopsy 25. Was case referred to medical ADHESIONS Be 26. Place of Death (Check only one) funeral director, Other: မှ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 \(\text{Yes} \) 2 \(\text{No} \) s after death.

I Director: After din by the fur 28f. Location (Street and Number or Rural Route Number,

Certificate: Medical

with the Maryland

Baltimore, Maryland 21215-0036

death certificate be executed

P.O. Box 68760

Division of Vital Records,

or Attending Physician; The

	1 ☐ Yes 2 🗙	No	Hos	р
ĺ	27. Manner of Death			2
	12 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending Investigatio 6 Could not be determined	oe 🖠	2

29a. Certifie

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	only one)		Nurse Practioner: To the best of					
2 9 b		nd title of certifier		29c. License number		29d. Date si		_
	Men	Mes 14	Sheistelles	DG6335	_	MAY	20,	20

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH GREENE ST BALTIMENE GEOFFREY > HENEEYD 22 31. Date filed (Month, Day, Year)

State Registrar

within 24 hours a

To the Funeral D

completed filled i Hospital

าบ-บวยบอ Reginald Mack, J	ir	State of Maryland / Department of Health and Mental		egible			
toginala Maok, o		1- For State Certificate of Death	riygiene	Dan No	201	0 1646	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of D			3. Time of Death	
Medical Examin		REGINALD MACK JR.	Month May 22,	Day 2010	Year	0037 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	eath	4c.	County of Deat	h	
		University Hospital Baltimore					
Funeral Director	Months Days Hours Min - 1/10/1007 Foreign					rthplace (State or	
Birector			11/10	0/190.	J C	puntry) DC	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neur of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
		MD Baltimore				1 X Yes 2 No	
	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?			
	칠	3861 McDowell Lane 21227		-	USA		
with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?		No- 1		ican Indian, Black,	
death or ite	Ĕ	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	eno Rican, etc.)		White, etc.	11-	
s after ral",	Completed by I	3 Widowed 4 Divorced If Yes, Give Year Unk 1 Yes 2 No specify:			specify.	lack	
hour "natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done retired)	16b. Ki	ind of Business	Industry	
36 hin 72 e. than	릙	12th Disabled Veteran		No	ne		
5-00 led wit Tygien other	팅	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle	, Maiden S	Surname)		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medican	a	Reginald Keith Mack, Sr. Zauny	Sr. Zaunya Crenshaw				
2 21 hould hould is ma	의	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number					
e, MD l and 2 sho Health and item 27 is	-	Lajonda Mack - Wife 155 Greenpoint Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Ports		, VA. 2		
of He		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Lc	ocation - City of	Town, State	
imc Page ment tant: or ot			7-2010		ington,	VA.	
Baltimore, ME permit. Pages I and 2 si Department of Health at Important: If item 27 injury or other trauma	-	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home of Maryland				1.6	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock,						Approximate Interval	
failure, List only one cause on each line.					,	Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					-	
		Sequentially list conditions, b					
	<u>[</u>	if any, leading to immediate Cause. Enter Underlying Cause					
	ğ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
executed an and al - transit	ical Examine	d.					
), be ext sician urial -	흸	UNPENDED					
68760, certificate be nding physici se as the buri	Š.	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnant 42 months 2 Fetal death 3 Ectopic pregnant 42 months 43 months 44 months 45 months 45 months 45 months 46 mo	anancy		Date of deliver	y Day Year	
OX 687 eath certification attending for use as t	<u>[</u>	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	grianoy		101101	, , , , , , , , , , , , , , , , , , ,	
Box e death o the atten	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown					
P.O. es that the igned by be detach	칠	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco us		the cause of death?	
lS, F quires an sign						stopsy findings available	
ords, aw requirents been to should	Completed		auto	opsy formed?		completion of cause of	
Rec The licate licate lipage	틼		1 Yes	2 No		es 2 No	
tal Reician: The certifica	<u>8</u>	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home, 5 Residence, 6 Other					
	의	1 Ves 2 No Pospital: 1 Inpatient 2 PER/Outpatient 3 DOA Outper Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred					
	Certification:	1 Natural 5 Pending May 21, 2010 2348 hrs 1 Yes 2 No Subject was shot					
Division tal or Attendir rs after death. al Director: A	<u>[</u> g	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3872 McDowell Lane, Halethorpe, MD				
Div ours aft ours aft filled in	팋	Suicide 6 Could not be determined (Specify) Walkway					
e Hosp 124 ho e Fune letely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	Σ	29b. Signature and title of certifier 29c. License number			ate signed (Mo	nth, Day, Year)	
X		My hi, med O.C.M.E.		May	22, 2010		
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta		31. Date filed (Month, Day, Year) 32. Refistrar's Signature					
S16	11:4	(month, way, roar)					

DHMH 17 Rev 1/2001 OCME 2006

10-03906 Robert Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Martin		STATE OF IVIA 1- For State Registrar	ryland / Departmen <i>Certificate</i>			rivienta	я нуд		eg. No. 2		1 1666
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Robert	2. Date of Do Month May 22				Day Yea	ar	3. Time of Death 0257 hrs		
		4a. Facility Name (if not institution, give street a	4b.	City, Town, or L	ocation of		May 22, 20	4c. County	of Death		
ノ		Johns Hopkins Bayview Medical	Center 7. Age (In yrs. last birthda		Baltimore	leate	0.41.1	O Data of Dis		ol o Bia	1-1
Funeral Director		5. Social Security Number 6. Sex 1X M 2		If Under 1 Year Months Days	If Under	Min	April 7	•	Foreign	hplace (State or n untry) Maryland	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation					-		10d. Inside City Limits
* .	ŗ	Maryland Baltimore	Duno	lalk							1 Yes 2 XNo
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	•	1	Of. Zip Code			10	Og. Citizen of WI	nat Coun	itry?
ith the 23a or notifie		7006 Railway Avenue	s Decedent Ever in U.S. 13) \\/(aa	21222 Decedent of Hisp		2/6	if . Van as Na	USA	Ai	can Indian, Black,
5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	uneral	1 Never Married 2 X Married Arm	ed Forces? Yes 2 X No		, specify Cuban,					e, etc.	can Indian, black,
after or ral", o	by F	3 Widowed 4 Divorced If Yes, Gir or Dates:	re Year			specify:			Specify:		
2 hour renatu		15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle			Usual Occupation t of working life.				16b. Kind of Bu	.siness/Ir	ndustry
vithin 7	Completed	12 years		0	wner				Tave:		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be Co	17. Father's Name (First, Middle, Last)			1			irst, Middle, M	Maiden Surname)	
212 ould be d Ment s mark	To E	Robert Leroy Martin 19a. Informant's Name/Relationship (Type, Print	100	-	ddress (Street	and Numb	er or Run	al Route Num	ber, City or Tow		
MD and 2 sho salth and em 27 is raumati		Jaclyn Martin 20a. Method of Disposition	wife 700		ailway A			undalk Date	, Marylai		21222
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygione. Important: If item 27 is marked other than "injury or other traumatic event, the Medical		1 Burial 2 X Cremation 3 Remo		or other	place)		May	26,		•	Maryland
Baltin permit. Pa Departmer Importan injury or		Donation 5 Other Specify: 21. Son ture Funeral Service Licensee			ne and Address nelly Fi	of Facility	20				
	12	plughes	/	711	0 Solle:	rs Po	<u>int</u>	Road,	<u>Dundalk</u>	,Md.	21222
Physician /Medical		23a. Pat I. Enter the disease, or complications to failure. List only one cause on each line.	e Gunshot Wounds	iter the	mode of dying, s	ucn as car	alac or re	espiratory arre	est, snock, or ne	art	Approximate Interval Between Onset and Death
Examiner			as a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
ecuted and transit											
50, te be exe ysician 2	Medical	UNPENDED AMEND									
876 rtificate ing phy as the t	W/ug		yes, outcome of pregnancy ive birth 2	Fetal	death 3	Ectopic p	regnancy	/	23d. Date of Month		ay Year
Box 68760, death certificate be he attending physic of for use as the bur.	Physician/	A No. 2 No.	Pregnant at time of death 5	Other	(Specify)						7
the by t			ing to death but not resulting in	the und	erlying cause giv	ven in Part	l.	23e. Did to	bacco use contri	bute to t	he cause of death?
rds, P.C requires that been signed I	ed by						_		220000		ably 4 Unknown
of Vital Records, ig Physician: The law require the tris certificate has been simeral director, page 2 should t	Completed						_ ′	24a. Was a autops perform	sy p		opsy findings available ompletion of cause of
		25. Was case referred to medical			26 Place	of Death (C	heck only	1 Yes 2		Yes	s 2 No
Vita hysician this cer	To Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 ✔ ER/Outpa	itient 3		Véh om			Residence 6	Other:	
- = ~ ≥ l		27. Manner of Death 1 Natural 5 Pending Ma	Date of Injury 28b. Time Month. Day Year) 28b. Time 22, 2010 0000 hrs	•	' _ ' '	at Work?	le.	d. Describe h	ow injury occurr	ed	
Division tal or Attendi rs after death. al Director: A	icati	2 Accident Investigation	Place of Injury - At home, farm,					f. Location (S	treet and Number	er or Rur	al Route Number, City
Div pital or ours afte eral Dir filled in	Certification:	Suicide Could not be	cify) Local Street				- 1	or Town, St			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical C	one) 2 Medical Examiner: On the b	e best of my knowledge, death of asis of examination and/or investors as total								
5 ± ½ ± 3	Me	29b. Signature and title of certifier	ner stated.		29c. License				29d. Date sign	ed (Mon	th, Day, Year)
		J.M. EE	- te		O.C.M	l.E.	_		May 23, 20	10	
1/1		 Name and Address of person who completed Ling Li, MD Assistant Medical E 	` '	treet,	Baltimore, M	ID 2120	1				
	ate		2. Registrar's Synature								· · · · · · · · · · · · · · · · · · ·
Regist	rar	1.8 5.4 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mayonth 24 20T0 12:45 ам Martin Pizzala Tom Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Delaware 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Days Hours May 11. Min. 222-44-5247 55 Director T955 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. ant I fitem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson 1 🗌 Yes 2 💢 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 15 East Burke Ave. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify Specify: White Completed 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Mark Urban F. Pizzala, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia Pizzala/ Mother 10 Courtney Rd. Wilmington, DE 19807 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1 Burial 2 🙀 Cremation 3 🗀 Removal from State 5-28-10 4 Donation 5 (a) Other (Specify) Hilltop Service Co. Towson, Md. ^{22. Name and Address of Facility}son Funeral Home, 1050 York Rd. Towson, Md. Service License 21. Signature Fun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ANL disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfor certificate 1 🗌 Yes Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes Investigation Accident within 24 hours after deal To the Funeral Director; Sulcide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie of death (Item 23a) (Type, Print) BUTIMORE, MO Wou 0101 31. Date filed (Month Day, Year) Registrar's Signature State DOS SINGLE Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year THOMAS PROCTOR JR. ALTON may Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 19<u>38</u> Days Hours Jan. 21 1 🖾 M 2 🗆 F 72 Director DC 579-50-8388 Usual Residence of Decedent ural", or items 23a or 28a-f show | Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Prince Georges Landover Hills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4209 71st Ave. 20784 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by **Maryland 21215-0036** If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify. 3 Widowed 4 Divorced Black traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9th Mechanic DC Government should be filed v and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Alton Proctor, Sr. Doreatha Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ft. Washington, MD. 20744 Felicia Wright - Sister 8701 Oxon Hill Rd. Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 5-27-2010 Brentwood, MD. 21. Signature of June 2 Service Licenses Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ Medical resulting in death) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ned by the a e detached f g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be o Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 patient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No 27. Manner of De th . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Date filed (Month, Day,

ThomA.

DHMH 17 Rev 7/2009

Registrar

strar's Signature

TREENBELT, NO 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 2

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4.56 A 2010 illiam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 5. Social Security Number 6 6. Sex 7. Age (In yrş. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Funeral 1 ▼ M 2 □ F Days Hours Min 21842 3070 Director 1944 Marvland Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director must be notified 1 X Yes 2 No Maryland N/ABaltimore 10f. Zip Code P 10e. Street and Number 10g. Citizen of What Country? 23a 21218 3113 St. Paul Street, Apt. 11 USA 2 should be filed within 72 hours after death v tth and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Oil Company 1.0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ James Α. Quinlan Margaret Pindell 1 and 2 should by Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 Bigley Avenue, Baltimore, MD 21227 Patricia Arthur (sister) or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the ease, or compli shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Suchas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transil Due to (or as a consequence of): attending physician for use as the burian Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Acoholism to the Funeral Director: After this certificate has been a completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes Division of Vital I 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural Natural Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D00677 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daltimo Po 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAY 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 2:00 PM May Elizabeth Avis Reec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Rossville</u> Manor Care Health Services 8. Date of Birth . Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 11/6/192 1 □ M 2 🛛 F West Virginia **Director** 234-52-9891 88 Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Middle River Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral S. 21220 A. 37 Cool Breeze Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sales Manager 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucy Spices John Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cool Breeze Drive Middle River, Maryland 21220 <u>Jennings Dennison (So</u>n) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem, Gard, 2010 Middle River, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Que to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should | peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2X No certificate has 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be within 24 hours after death To the Funeral Director: A Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the e and title of certifier 29d. Date signed (Month, Day, Year) 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) AS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 Registrar

DHMH 17 Rev 7/2009

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68760	ertifica ding ph	/Me	IF FEMALE:		230	c. If yes, outcome	of pregna	incv				- 8	00d Data of a	-15	-
Box	e death or the atten- ned for us	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	Ectopic pregnan Other (specify)	су			23d. Date of c Month	Day Year	
P.0.	that the	y Ph	Part II. Other signi	ficant condition	ns cont	ributing to death	out not res	sulting in the u	ınderlying cause g	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
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Division of Vital	nding Ph ath. : After thi e funeral	cate:	27. Manner of Deat 1 Natural 2 Accident	h 5 🗌 Pendin Investic		28a. Date of inju (Month, Da	Jry	28b. Time of injury	28c. Inju	y at	28d. Describe				
ivisio	Il or Atte after des Director	Certif	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, str	eet, factory, office		28f. Location City or To			ural Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical Certificate:	(Check 2	Medical E	xamine	r: On the basis of	examination	n and/or inves	tigation, in my opin	on, death occ	ace, and due to the curred at the time, date and place, and due to the time.	and place	e, and due to the	e cause(s) and manner star	ted.
	To the within To the compl	2	29b. Signature and	title of certifier	-	20000110001	200:01111	, moage, '	29c. Licens		passoj una duo to		ate signed (Mor		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Physician/ JOSEPH THOMAS RAGONESE 24 3:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE & PALLIATIVE CENTER Randallstown Baltimore County 8. Date of Birth Mar 11, 1934 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 ₹ M 2 □ F 76 Mar Director 2<u>13-30-5161</u> Ohio Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 😾 No Maryland Baltimore County Towson 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 409 Virginia Avenue, Apt 411 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 157-163 Black, White, etc. 1 Never Married 2 Married Completed by altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) County Government Construction Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Leonard Ragonese Frances Savoca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Ragonese <u>33 Mopec Circle, Apt B. Nottingham, </u> MD_21236 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Valley Mem Grdns! 5/28/2010 Timonium, Maryland 21. Signal / Fugeral Service Licens

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ling disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the filled in by the funeral director, page 2 should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be inputient examiner? Hospital 1 🗌 Yes Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No 5 \square Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

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completed f (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number ZS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARTIMONE, MD 2835 SMITH MEKALITI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ODICINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** May 2010 /Medical give steet and number) City, Town, or Location of Death Eacility Name (If not institution, County of Death **Examiner** a If Under 24 I 8. Date of Birth (Month, Day, Year) If Unde Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 X F Yrs. Director 88 19,1922 MD Jan. 217-14-1340 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Carrol1 New Windsor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1050 Western Chapel Road 21776 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor MD Cup Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Charles Alder Julia May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1050 Western Chapel Road, New Windsor, MD 21776 Daughter Bonnie Cummins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Druid Ridge Cemetery 5/26/2010 Pikesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Par disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 2 300 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 ☐ Pending investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R100599 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonnie 5 Dank CRNP, 710 Obrech-710 Obrecht Rd, Sykesville, MD Bonnie 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25. 2010 Sowden, Sr. James 7:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 8194 Brandon Drive Millersville Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV . 10 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 🖾 M 2 🗆 F Year 1946 63 Washington Director 465-72-3132 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho many injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Millersville Maryland Anne Arundel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8194 Brandon Drive 21108 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: 166-170 Completed White Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Customer Service Rep. Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerry F. Sowden Elizabeth Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Sowden / Wife 8194 Brandon Drive, Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State onation 5 Other (Specify) Metro Crematory, Inc Catonsville, Maryland 4 🗆 d Name and Address of Facility
rk ley-Ruddick
I Crain Hwy., S.E., Glen Burnie, Signat Licens MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ isosce 5 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that better the cause of t Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform 2 X No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $\stackrel{1}{\boxtimes}$ Residence 6 \square Other (Specify) 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

10v

State Registrar

DHMH 17 Rev 7/2009

29b. Signature a

31. Date filed (Month, Day, Year)

26

of certifier

Russell R. DeLuca, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D31551

305 Hospital Drive, Glen Burnie, Maryland 21061

29d. Date signed (Month, Day, Year)

May 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	rs, Sr. State of Maryland 1- For State Registrar	/ Department of Certificate of	i Health and Mental H i Death	ygiene Reg. 1	No. 2010	1647	
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) RALPH THOMAS SPEARS			2. Date of Death Month Da May 15, 2010	ay Year	3. Time of Death 1151 hrs	
	4a. Facility Name (if not institution, give street and number 3715 Washington Boulevard # 109)	b. City, Town, or Location of Death Halethorpe		4c. County of Death Baltimore Cou	ntv	
Funeral	5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	—	MM/DD/YYYY) 9. Birt	place (State or	
Director	220-50-9657 1XM 2F	63 Yrs.		Dec. 3,	1946 co.	Wash DC	
¥ any	10a. State 10b. County	10c. City, Town or Locati				10d. Inside City Limits	
ne Maryland or 28a-f show any fited at once.	MD Baltimore 10e. Street and Number	Halethorp	e 10f. Zip Code	1100	Citizen of What Coun	1 Yes 2 XXNo	
the Maryland a or 28a-f sh tified at onco	1204 Elm Road		21227	l log. v	U.S.A.	uy?	
or items 23. must be no	11. Marital Status 1 Never Married 2 Married Armed Forces'		L s Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		14. Race - Americ	an Indian, Black,	
fter dea	1 Yes 2 Widowed 4 XX Divorced If Yes, Give Year	XX No	Yes 2XX No specify:	, ,	Specify: Whi	te	
hours a matural samin ed by	or Dates: 15. Decedent's Education (Specify only highest grade cor	npleted) 16a. Decedent	s Usual Occupation (Give kind of v		b. Kind of Business/Ir		
5-0036 ed within 72 hours afth tygiene. other than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-4 or Grade 12	5+)	1 Contractor	,	Construct	ion	
15-00 iled wit Hygien d other the M	17. Father's Name (First, Middle, Last)			(First, Middle, Maid	en Surname)		
2121 bould be fil d Mental I is marked tic event,	Louis T. Spears 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Marie A	. Wrenn	. City or Town. State.	Zip Code)	
MD d 2 sho lith and lith and aumatic	Cami Conditt / daughter	1204	Elm Road Haleth	orpe, Mar	cyland 21	227	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 XXCremation 3 Removal from St	ate 20b. Place of Disposi crematory or oth West Arun	tion (Name of cemetery, er place)	Date 20 20 20 21 20 10	c. Location - City or 1	own, State , Maryland	
altim nit. Pag artmen sortant rry or o	4 Donation 5 Other Specify: 21. Signature of Funeral Fervice Licensee		ame and Address of Facility na 1 d son Tunieral			, Haryrana	
	45th 1	M00770 31	3 Talbott Avenue	Laurel	, Maryland		
Physician	failure. List only one cause on each line.		e mode of dying, such as cardiac or		.	Approximate Interval Between Onset and Death	
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Zolpidem Due to (or as a constitution or condition resulting in death)	toxicity cor equence of): cardio	mplicating ather ovascular diseas	e e	С		
-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a const						
0, e be executed sician and burial - transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	equence of):					
ecuted and transit	d.	,					
ob, te be executed ysician and burial - transit	IF FEMALE: 23c. If yes, outcor	28a-f,per MI	E g903 5/27/10 T	Г			
ox 6876 eath certificate attending phy for use as the trsician/M	23b. Was decedent pregnant in the past 12 months?	ne of pregnancy 2 Feta	al death 3 Ectopic pregnal	12	23d. Date of delivery Month Da	y Year	
Box 6876 e death certificat the attending phy ed for use as the hysician/M	1 Yes 2 No 9 Unknown 9 Unknown	time of death 5 Oth	er (Specify)				
that the ted by detach	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Part I.		o use contribute to the		
ords, F w requires s been sign should be.				24a. Was an	pt house.	psy findings available	
Division of Vital Records, tal or Attending Physician: The law requires rs after death. "In Director: After this certificate has been signer or the fineral director, page 2 should be ertification: To Be Completed				autopsy performed 1 Yes 2	? death?	mpletion of cause of	
Vital Recysician: The Institute of Be Com	25. Was case referred to medical examiner?		26.Place of Death (Check of		1 163	2 110	
n of Vit ding Physic hafter this funeral dire	examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Inju			Home 5 Resi	dence 6 Other:	Scene	
ision C Attending or death. rector: Af by the fun ication	Natural 5 Pending Pend	ear)	1 Yes 2 X No	unk	.,,		
Division o spital or Attending nours after death neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X Could not be 28e. Place of In		factory office building etc.	28f, Location (Street or Town, State)	t and Number or Rura 3715 Washi	Route Number, City Ington Blvd	
Hospital 14 hours Funeral cely fillec	4 Homicide determined (Specify) M. 29a. Certifier 1 Certifying Physician: To the best of my						
2 # 2 ¤ L	one) 2 Medical Examiner: On the basis of examiner and manner stated.		on, in my opinion, death occurred at	the time, date and p	olace, and due to the	cause(s)	
Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.	1.0	d. Date signed (Monti ay 16, 2010	h, Day, Year)	
	30. Name and address of person who completed cause of d	eath (Item 23a)					
NJ	Ana Rubio MD. Assistant Medical Exam 31. Date filed (Month, Day, Year) 32. Fegistrar	de Signatura	reet, Baltimore, MD 21201				
State Registrar	MAY 2 6 2010 Access	A Mari	les				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

UUIME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year PM 29 2010 Kosina a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 1 □ M 2 💢 F Days 218-36-9508 Yrs 70 August 6, 1939 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 USA 1805 Crafton Avenue 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Hair Salon 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Russell Roland Goodwill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 1805 Crafton Avenue, Dundalk, Maryland 21222 John Hiotes son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 22, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 Bayview Crematory Signature of Functal 22. Name and Addi Connel IV Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Onset and Death Immediate Cause (Final Terminal 15 years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ovarian Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

ral", or items 23a or 28a-f s Examiner must be notified

"natural",

th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I

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injury or other nent of Hea

Important: It any injury o once,

Director

Funeral

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Completed

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Examine

Physician/Medical

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed Be

The law requires that the death certificate be executed physician and is the burial-trans use as for page 2 should be detached signed by this certificate has Physician: filled in by the funeral director, Il or Attending P safter death. Director: After t 24 hours a Hospital

Division of Vital Records, P.O. Box 68760,

State

within 2 To the I

the

Medical Certification: 29b. Signature and title o

25. Was case referred to medical

2 No

5 Pending investigation

6 Could not be

determined

examiner?

27. Manner of Death

Natural

2 Accident 3 Suicide

4 🗌 Homicide

29a. Certifier (check only

one)

29c. License number

28c. Injury at Work?

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes

26. Place of Death (Check only one)

Other: 4 Nursing Home

2 🗌 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

3010

5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number,

600 North Wolfe St, Baltimore, MD, 21287

28d. Describe how injury occurred

City or Town, State)

who completed cause of death (Item 23a) (Type, Print)

Ke

1 Inpatient

Year)

28a. Date of Injury

(Month, Day

31. Date filed (Month, Day, Year) 32. Registrar's Signature 26 2010

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

amend #195 Per Maryland / Separtification of Health and Mental Hygiene amend #5 Per FH G911 1/26/16/2016 of Death 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** Selzer M OOPI Kaymond awrence 2010 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Doctor Ijamsville 9. Birthplace (State or Foreign Country)
Washington, DC 5.690 Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 0 ct 1, 1932 7. Age (In yrs. last birthday) **Funeral** Days Months 578-48-5061 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Madical Examinations in an additional Ijamsville 1 ☐ Yes 2 No MD Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21754 USA 9802 Doctor Perry Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 1953 — If Yes, Give Year or Dates: 1954 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 white 1 ∐Yes 21X No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) construction excavator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Ann Retzler Lawrence Martin Selzer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6300A 01d Middleton Road; Middleton, MD 21 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once. MD 21709 Kirk Selzer/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 21. Si nature of Fuoral Service Rona Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Came (Final YCAFS **Physician** Due to (or as a co sequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 > o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate | 1 □Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 4 ☐ Homicide 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Teague May 2010 3:30am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 315 Nicodemus Road Reisterstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Hours 410-40-9115 80 Director 8-25-1929 NC Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Nicodemus Road Funeral 21136 United States 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1 0 5 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1951 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced 1953 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Year Self Employed Cabinet Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Teague ပ Myrtle Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trau once. Mary J. Teague (wife) 315 Nicodemus Road Resiterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 5-26-2010 Sykesville, MD Fun Service Licensee 22. Name and Address of Facility 21, Sign ELINE FUNERAL HOME J. Wayne Osterling 11824 Reisterstown Road Reisterstown, MD 21136 23a. art 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or hearth silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate () (Find I disease or condition resulting in death) le & Kemia 125ma C 2 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Knowh 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Physician /Medical **Examiner**

with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

nd Mental Hygiene. marked other than

and I

traumatic

sician and burial-trans attending physician for use as the burial signed by the best of the signed of the signed by the signed of the signed by the signed of the sign page 2 should certificate e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director. p

P.O. Box 68760,

Division of Vital Records,

Certification: To

within 2

29a. Certifier Medical (Check only 29b. Signature and title of certifier

27. Manner of Death

atural

3 Suicide

2 Accident

4 Homicide

5 ☐ Pending investigation

6 Could not be determined

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)\

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

em 23a) (Type, Print)
23 Chossroads Dr. Ste#343 Usings Mills md. 21117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D

2 32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / [Department of Health and N Certificate of Death	Mental Hygier		16483			
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) VIRENE TINSLEY		Metry -	Day Year	3. Time of Death			
	Examir Funeral Director	ner	214-20-0094 01	4b. City, Town, or Location of Death Reserved If Under 1 Year Wunder 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 01 26	POAL Zan POAL Z	place (State of Foreign VA			
	e Maryland sa-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD NA	m or Location Baltimore		1	0d. Inside City Limits			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examera must be notified at once.	Be	ToB	John Davis 19a. Informant's Name/Relationship (Type, Print) Lelia Davis—Daughter 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State	ngham Road 12. Was Decedent Ever in U.S. Armed Forces? 1					
8760,	Certificate be executed Medical Examiner Aging physician and See as the burial-transit	cal Examiner	dlcal	dlcal	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the condition of the condition of the cause in the cause in the cause in the cause in the cause in the cause in the cause of the c	on pui 4		re, Md 2	Approximate Interval Between Onset and Death	
O. Box 68	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ry Day Year			
VISION OF VITAL HEC	Attending Physician: The law requires t ar death. ector: After this certificate has been signe by the funeral director, page 2 should be a	ertification; To Be Completed by Phy	Concoracy Antiny District Concoracy Antiny D	26. Place of Death tratient 3 DOA Other: 4 Nursing Hor	24a. Was an autopsy performed?	24b. Were autopprior to condeath? 1 Yes 6 Other (Specify ury occurred	ably 4 Danknown osy findings available notestion of cause of 2 Data			
a	Hospital 24 hours a Funeral I	edical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, a d/or investigation, in my opinion, death occurre	ed at the time, date ar	nd place, and due to	the cause(s)			
	To the comple	Σ	29b. Signature of title of certifier 30. Name and address of person who completed cause of death (Item 23a) (29c. License number D(\$50 > Type, Print) Non 74	29d. D.	ate signed (Month, E	Day, Year)			
	Sta Registra		31. Date filed (Month, Day, Year) 32 resistrar's Signature	hald	BWN, and	Rylando	2433			

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 🤈 🖺 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 2010 9:40P FLORENCE M. WILSON Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE TOWSON GILCHRIST CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Davs Hours Min. April 22. 1 □ M 2 🕱 F Mary Land 77 Yrs 212-32-6853 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 📉 No Baltimore County Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21221 741 Sue Grove Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗶 No à 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3√ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 yrs. Homemaking-Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental ant: If item 27 is marked o Caroline Maydwell ပ Christian Liersemann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7130 Olivia Rd. Baltimore, Maryland Caroline F. Bates (Daughter) other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o Holly Hill Cemetery 1 X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-27-2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Balt 21. Sign at re of Funeral Service Lice see Baltimore, 23a. Part 1. Enter the disease or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ moths Metastedic MORONO disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death a 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k ģ 2 No 3 ☐ Probably 4 ☐ Unknown FIDUIDALA 1 Tyes Records. anal Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be **Division of Vital** examiner? Hospital Other: 2 100 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

To the I within 2

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R1453

AMEND TTEM#20b,c.perFH.G904.6/11/2010 WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Wood William Mervinis 05 2010 :00a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchirst Hospice Towson 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X**☐ M 2 ☐ F Davs Hours Min. Director 229-38-7228 76 Usual Residence of Decedent and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at. permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho mirportant: If tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at, any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3430 Hilldale Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. ۾ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Steel Worker 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Viola Blue Clarence Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilldale Place, Baltimore, Md 21215 Richetta Wood-Wife 3430 Baltimore, 20b. Place of Disposition (Name of _______ 20a. Method of Disposition 20c. Location - City or Town, State 6/11/2010 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mills, Donation 5 C Other (Specify) U Forest Vet 21. Signature of Funeral Service Licens 22. Name and Address of Facility
March F/H West 300 Wabash Baltimore, 21215 Ave, 23a. Par 1. Enter the disease, or complications that caused shock, or heart diure. List only one cause on each line. Immediate Cause (Final ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death bRin Ph_sician/ MOXIE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Noncer the Nospital of Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical I Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 1 Tes 2 No hospip Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this To the recent within 24 hours after death.

To the Funeral Director: After this standard in by the funeral 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 82 21 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an vocal CHANCE 1 North 31. Date filed (Month, Day, Year)

MAY 26 2010 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylan		artment of F		and Me	_	giene Reg. No	010	164	87
	Physicia		1. Decedent's Name (First, Middle, Last)							2. Date of De Month May		2 ₩10	3. Time of 8:45	
	Medic Examir		4a. Facility Name (if not institu Stella Maris	tion, give street and num	ber)		4b. City, Town, or Timoni		f Death					
	Funeral Director		5. Social Security Number 215-22-8693	6, Sex 1 □ M 2 X F	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 2 Hours		8. Date of Bir Aug 25	th y, Year 920	9. Birthpl Mary	ace (State or and	Foreign
-	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. Cou MD Wo	nty rcester		y, Town or Loc						10	d. Inside City	
	the Ma a or 28a be notif	Funeral Director	10e. Street and Number		1 00	Can OI	10f. Zip Code				10g. Citizen	of What Count		24 No
	nust	nerë	14113 Fiest	a Road			21842				USA			
р.ш. 215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ I 3 ☑ Widowed 4 ☐ Divor	Armed For 1 ☐ Yes If Yes, Give Year or Da	23/C No	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🖾 No	Specify:	in? (Speci Puerto Ri	fy Yes or No- ican, etc.)	E	Race - America Black, White, e cify: Whit	c.	
. р.ш 21215-	/ithin 72 ho iene. r than "na the Medic	Completed by		edent's Education ghest grade completed) 2) College (1-	4 or 5+)	16a. Deced (Give k life. DO nu 1	ent's Usual Occupa ind of work done of NOT use retired)	ation <i>luring m</i> ost o	of working	7		f Business Indi	ustry	
8:45 land	and 2 should be filed within Health and Mental Hygiene. em 27 is marked other the ther traumatic event, the I	To Be	17. Father's Name (First, Middle Charles Sell		ım					First, Middle, Lizabet				
2010 9, Mary	2 should th and N 7 is ma trauma	2.39	19a. Informant's Name/Relation			1	g Address (Street a							
IAY 15, 2010 8:45 Baltimore, Maryland 21	age 1 and ent of Heal nt; If item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremati 4 Donation 5 Othe	on_3 Removal from		lace of Dispos	sition (Name of atory or other place		Da u			on - City or Tov		
MAY 1 Baltin	permit. Page 1 Department of Important; If it any injury or o		21. ignatur Funeral Service Conal		czor	St St	Name and Addres	s of Facility	oard;	655 W	. Balt	imore	Street	
			23a. Part 1. Enter the disease shock or heart failure. Li	, or complications that cast only one cause on each	aused the death th line.	n. Do not ente	1timore , rthe mode of dying	Mary g, such as ca	Land- ardiac or r	21201 respiratory arr	est,		Approximate Interval Betw	reen
•	Medical		Immediate Cause (Final disease or condition resulting in death)		IC OBS		E PULMON	ARY D	ISEAS	SE		-	Onset and De	eatn
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequ	ence of):								
09	certificate be executed nding physician and use as the burial-transit	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (c	or as a consequ	ence of):								
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown		Birth 2 □ Feta ant at time of d	I death 3 🗌	Ectopic pregnance Other (specify)	у				Date of deliver Month [y Day Ye	ear
NGTON ds, P.O	equires that the sen signed bould be deta	by	Part II. Other significant conc	litions contributing to de	ath but not resi	ulting in the ur	derlying cause giv	en in Part I.	_	23e. Did to	٠	ontribute to the		
MARY WHITTINGTON Division of Vital Records, P.	: The law re cate has bu ; page 2 sh	Completed								24a. Was a autop perfo	sv	b. Were autops prior to com death? 1 \(\sum \text{Yes} \) 2	pletion of car	vailable use of
7 W /ital	sician certifi irector	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 X No	Hospital:	npatient 2 🗆	ED/O. 4	Otho	r:	``		. V 1		HOCDTO	212
MARY on of Vi	nding Phy ath. r: After this e funeral d	icate: To	27. Manner of Death 1 Natural 5 Per	28a. Date o		28b. Time of injury	28c. Injury work	at	28	d. Describe h		ther (Specify) urred	RUSFIC	<u> </u>
Divisio	al or Atte s after der il Director ed in by th	l Certificate:			of Injury - At hor g, etc. (Specify)		et, factory, office		28	f. Location (S City or Tow		nber or Rural F	oute Numbe	r,
	he Hospit in 24 hour he Funera ipleted filk	Medical	(Check 2 Medica	ing Physician: To the be al Examiner: On the basi ing Nurse Practioner: To	s of examination	and/or investi	gation, in my opinior	n, death occu	urred at th	e time, date a	nd place, and	due to the caus	e(s) and manr	ner stated.
	To t with To t		29b. Signature and title of certi	fier ISLANS	•		29c. License	number 4192	2		29d. Date sign	ned (Month, Da		
			30. Name and address of person	on who completed cause			int)	TTMAN	TID4	MD 21	002	ř		
	Stat Registra	e	31. Date filed (Month, Day, Year	32. Fe	gistrar's Signati		arkel	TIMUN	LUM,	- FID - Z I	∪ y 3			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May Year Young 16.30 0 M **Physician** ZO Cephes 20,0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 3/23/1945 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 XM 2 ☐ F Months 65 439-70-5129 LA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State show Severn MD Anne Arundel 1 ☐ Yes 2 X No Director items 23a or 28a-f s ner must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21144 USA 1415 Larch Rd. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 11. Marital Status traumatic event, the Medical Examiner 1 Never Married 2 Married Specify: Black Ь Maryland 21215-0036 1 ☐ Yes 2 X No Yes, Give Ş Q 3 Widowed 4 Divorced Year or Dates "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4 or 5+) U.S. Army Dental Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fil ment of Health and Mental H ant: If item 27 is marked ott Franklin Cephes Carrie Young Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 1415 Larch Rd., Severn MD 21144 Anita A. Young/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 5/29/2010 Catonsville MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 Signature of Funeral St M01364 stions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final **Physician** ardionyofath disease or condition resulting in death) /Medical Due to (or as a lone equence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending nse 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ pe 4 Unknown 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed page 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No မ After this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: (Month, Day Year) Injury 5 Pending investigation 2 □ No M 1 Yes death. 2 Accident after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in by 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number RES -000 20

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shanaha

Kyan 31. Date filed (Month, Day, Year) 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ Michael Charles Zyla, 010 8:104 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4125 Raymonn Avenue Balto. 8. Date of Birth
(Month, Day, Year)
August 22,1929 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F Months Director 220-22-4485 80 Marv1and Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Ty Yes 2 No Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4125 Raymonn Avenue 21213 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2
If Yes, Give 1 Black, White, etc. 1 Never Married 2 Married 2 🗌 No Completed by Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Year or Dates 1949-1954 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 8\,th \end{array}$ College (1-4 or 5+) Electronic Technican U.S. Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Jaskulska Michael C. Zyla, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto. Md.21213 4125 Raymonn Avenue Martha Zyla Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 5-26-2010 Dundalk. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Deensee Schimunek Funeral Home 9705 Belair Rd Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosderoti Cardiovuo ulo Disens Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been PancreatinCancer 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? , page 2 autopsy performe 1 ☐ Yes 2 ☐ No Diabetes Yes 2 25. Was case referred to medical examiner? completed filled in by the funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or inventigation in my animal death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

3100 Wyman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAURA T. McGuirce

MO

32. Registrar's Signature

29c. License number

D33307

Park Drive, Baltime mo 2121

5/24/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Jose Armando Barrientos Avila Physician/ May 2, 2010 8:45 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 🗷 M 2 🗆 F Months Days Hours Min. May 24, 1930 El Salvador Director Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? Funeral 23a death with 806 Dryden Street 20901 El Salvador items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 X Married 2 🔀 No filed within 72 hours after Yes Baltimore, Maryland 21215-0036 White XX Yes 2□No Specify: Salvadorean If Yes, Give Year or Dates 3 Divorced "natural" other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1.1 Typist Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant; If item 27 is marked o ပ Norberto Barrientos Ernestina Avila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Alicia Barrientos/Wife 806 Dryden Street, Silver Spring, MD 20901 Department of Healt Important; If item 2 any injury or other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 6, 2010 Cremation 3 🔲 Remo Gate of Heaven Cemetery 4 Donation /5 Dother (Specify) Silver Spring, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed and burial-tran that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant **22**3 of delivér 3 Ectopic or 5 Other (spe in the past 12 months? Day Month 4 Pregnant 9 Unknown Pregnant at time of death 2 No 9 Unknown 7 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use co fribute to the cause of death? þ NZUMONIA or Attending Physician; The law requires Records, Completed 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown SEPTICEMIA 24a. Was an 24b. Were autopsy findings available autopsy perform prior to completion of cause of death?
1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) 1 K Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2X Accident injury 5 Pending work? 1 ☐ Yes 2 💆 No 2010 n 24 hours after death.

le Funeral Director; Af
bleted filled in by the fu UnKM Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number HOSPITAL Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Myedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completed fi (Check rtifying Nurse Practioner: To the bes of my ky wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) May 5, 2010 D59199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joshua Katz, MD 9715 Medical Center Drive, #233, Rockville, MD 20850

State

Registrar

31. Date filed (Month, Day, Year)

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Delmer Sylvester Behringer 2010 a 00:11 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 560 West Drive Severna Park If Under 1 8. Date of Birth (Month, Day, Year) July 14,1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 □ F Hours Pennsylvania 218-22-3847 Director 82 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Severna Park Anne Arundel MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 560 West Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? 1945-1 X Yes 2 No 1946 Black, White, etc. 1 Never Married 2 X Married þ 1946 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Sign Electrician 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other ပ Laura Timlin Charles Behringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 560 West Drive Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) 560 West Drive Vera Behringer / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause or each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death Physician/ W disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last sician a burial-1 Physician/Medical phys the L attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f Unknown 9 Unknown ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown has been sig je 2 should b Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate funeral director, pag 2 1 2 🗌 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural work 5 Pending hours after death.

neral Director: Aft
d filled in by the fur 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a
To the Funeral C
completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat0re and title of pertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caus eath (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 50P 2010 BURNS SELMA CATHERINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner Itimore 5+ Agnes
5. Social Security Number Hospito 8. Date of Birth (Month, Day, Year) SEPT. 28, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2√1X F NEW YORK Director 103 14 2855 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "waited Evan nor must be notified at any Injury or other traumatic event, the "waited Evan nor must be notified at any Injury or other traumatic event." 10a. State 10b. County 1 ☐ Yes 2 No Director MARYLAND BALTIMORE CATONSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 709 MAIDEN CHOICE LANE RGT 408 21228 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify:WHITE 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) CHILDRENS LIBRARIAN CLERK VILLAGE OF LINDENHURST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ WILLIAM KURTZ SMITH AMOLIA ABOL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON R. COOK (DAUGHTER) ANNAPOLIS, MARYLAND 625 WOOD LOT TRAIL 21401 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KALAS CREMATORY 05-08-2010 EDGEWATER, MARYLAND 22. Name and Address of FacilityGEORGE P. KALAS FUNERAL HOME MI 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD, 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myocardial **Physician** acute days disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1□ Yes 2 100 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47009 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) hoice Lane, Baltimore one

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **2010** Year Physician/ May 16. 3:05 A M Mary Cyrilla Beck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24375 St. Mary's Beck Road Hollywood Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min. (Month, Day, Year October 29 1 M 2 X F Director 216-22-3535 Maryland Usual Residence of Decedent show 10h County 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at. 10a, State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🕱 No Marvland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 USA 24375 Beck Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bank Teller Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth Albert Warren Greenwell Catherine Agnes other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Xavier Norris / Nephew 23030 Hayden Ct. Lexington Park, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 20,2010 Department or Important: If any injury or John's Cemetery Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. In a ure of Foneral Service bicer Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Our to for an a purieucusines of Cause (Disease or iinjury and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death 2 No a 🗌 Unknown 9 | Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has l autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 27. Manner of D th 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural injury work' 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

To the within 2 To the F 10 C+7675 State

24 hours after deat Funeral Director; Medical сопрете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D00506 May 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28170 Old Village Rd. Berube, MD Mechanicsville, MD Leon W.

1 Yes

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

filled in by the

Accident

Suicide

4 Homicide

29a. Certifier

(Check

Investigation

determined

6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}**2010** Physician/ Month Mav Raymond Francis Bayerle 5, 11:40 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) Italy 1 M 2 D F Months Days Hours Min. May 11 Pay 946 216-50-2553 63 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland notified at 10d Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 2711 Spencer Road 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black White etc ö 1 Never Married 2 Married Yes 2 No \$ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Physician Medical. traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ္ Conrad Raymond Bayerle Santina Pesce ige 1 and 2 should but of Health and Mer t: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Santina P. Bayerle/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Spencer Road, Chevy Chase, MD 20815 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 7 Date cemetery, crematory or other place
Metropolitan Crematory 1 Burial 2 K Cremation 3 Removal from State Department o Important: If any injury or once. ò Alexandria, Virginia 4 Donation 5 Other (Specify) 2010 Frame and Adversify Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed after death.

Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice Other: 2 😧 No 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation the f Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu re and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 Diane Ruckert, CRNP 31. Date filed (Month,

DHMH 17 Rev 7/2009

State

Registrar

racket

2. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 010 11:58 A Ellis J. Berne May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Suburban Hospital</u> <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) 04/27/1928 Birthplace (State or Foreign Country)
 NY
 NY . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 1 X M 2 □ F Hours Director 82 099-32-9434 Usual Residence of Decedent "natural", or items 23a or 28a-f show a rical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me ical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1X Yes 2 ☐ No MD Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 5 Van Dyck Ct 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Esther Zucker Oscar Bern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Daughter Van Dyck Ct. Potomac. MD 20854 <u>Ellen Berne</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2010 National Crematory Falls Church VA Signature of Funeral Service Licensee 22 Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville, MD 20852 Kurt Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examiner Clostridium Difficile Colitis Recurrent Securintially list condition Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hypotension 2nd to Sepsis and Adrenal Insuff attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical End_stage Renal Disease IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown ģ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Records, Completed Cardiac Bypass Surgery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy director, page 2 performed? Yes 2 X N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛚 No မှ 1 K Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Division of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | 3 | I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 065312 SUDARSHAN SWA 5/3/10 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgrtown Road Bethesda MD 20814 Siva M.D Sudarshan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11

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Registrar

5/3/10 1158 AM

Ellis

BERNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maynth 1, 2010 Physician/ 755 PM M Joseph Birenbaum Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner 6111 Montrose Road #1023 Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □**X**M 2 □ F 84 Director 33-16-5230 13. NY March Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 6111 Montrose Road #1023 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give WW II Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Liquor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kuni Birenbaum Annie Fleischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Fran Rapport - daughter 16656 South Pecos Road Prineville OR 97754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 X Removal from State New Montefiore Cem 5/6/2010 Farmingdale, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville 20852 21. Signature of Funeral Service Licensee M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or imjury that initiated events that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Preanant at time of death 9 Unknown Division of Vital Records, P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ulcerative Colitis has page 2 s performed this certificate 1 ☐ Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this α completed filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Kalman MD 1396 Piccard Drive Rockville MD 20850

32 Registrar's Signature

back

29c. License number

D20367

29d. Date signed (Month, Day, Year)

May 3, 2010

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	Otate of Wit	ai yiai i	•	tificate of l			iontai riy	Reg. No			
	Physicia	n/	1. Decedent's Name (First, Middle, Las		2. Date o					ay Year	3. Time of Death			
	Medic	al	Catherine Wheeler				# OF T	(5, 1)	May 4		10	9:15 A.M		
	Examin	er	4a. Facility Name (if not institution, give Spring House of B		4b. City, Town, or Location of Death Bethesda					4c. County of Death Montgomery				
	Funeral		5. Social Security Number 6. S	st birthday)	If Under 1 Year Months Days		er 24 Hrs.	8. Date of Bir	th	9. Bit	thplace (State or Foreign			
	Director		219-36-8268	Yrs.	Months Days	Hours	IVIII.	DEC. 1	6, 1	913 Sou	th Dakota			
	nd how at	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ins									10d. Inside City Limits		
	tarylar 3a-f s ified	ecto	Maryland Montgomery Bethesda							1 ☐ Yes 2 🛣 No				
	the N or 28	I Dir	10e. Street and Number		10f. Zip Code		_	-	10g. C	itizen of What Co	ountry?			
	h with	Funeral Director	4925 Battery Lane				20814					ted Sta	tes	
	r item iner n		11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic C an, Mexic	rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
20	s after al", o Exam	d by					☐ Yes 2 🔀 No	Specif	fy:			Specify: Ca	ucasian	
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7	ed wit Hygie other	Be C	17. Father's Name (First, Middle, Last)	4	ļ	Sewing	Sewing Instructor 18. Mother's Name (First, Midd						ducation	
yland	be file ental 'ked c	2	William Archie Wh	eeler						Alden	Maiden	Juniame)		
Mary	hould and M s mar		19a. Informant's Name/Relationship (T)			19b. Mailin	g Address (Street	1			er, City o	r Town, State, Zi	p Code)	
Σ	nd 2 sl ealth a n 27 i ier tra		RICHARD ALLEN LI	NES / SON	_	18 GA	RRISON L	ANE,	MADBI	URY, NH	038	323		
9 9	ie 1 ar t of Hk If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	20b. Pi	lace of Dispo emetery, cren	sition (Name of natory or other plac			Date	ł	ocation - City or		
Dalumor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	7	4 Donation 5 Other (Specif	ý)	At1		ntic Crematory 05/10/2010 G1 22. Name and Address of Facility Thibadeau Mortuary Service, 7 Park Avenue, Gaithersburg,							
0	permi Depar Impor any ir	. 3	21. Signature of Funeral Service Licens	In 1	40150)8 T	. Name and Addre Nibadeau Park Ave	Mort nue.	uary Gait	Service	e, p	.a. MD 2087	7	
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	ificate be executed og physician and as the burial-transit	EX	resulting in death) Last	Due to (or as a	consequ	ence of):								
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<u> </u>	an: Th tificat tor, pa	Be C	25. Was case referred to medical				26. P	lace of De	eath (Check	1 Yes	2 L X N	o I L Ye	s 2 No	
7	hysici his ce I direc	To E	1 ∐ Yes 2 L∡AJNO		_	ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗌 I	Nursing Ho	me 5 X Resid	dence 6	6 ☐ Other (Spec	oify)	
5	ding P h. After ti funera	Certificate:	27. Manner of Death 1. A Natural 5 Pending	28a. Date of injur (Month, Day,		28b. Time of injury	28c. Injur work M 1 🗆	yat <br Yes 2[28d. Describe h	now injur	y occurred		
	Atten	rtifi	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inju	ry - At hor	ne, farm, stre							ral Route Number,	
2	ital or irs afte al Din led in l			building, etc.	. (Ѕресіту)					City or Tow	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exami	sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination	and/or invest	igation, in my opinio	on, death	occurred at	the time, date a	and place	and due to the	cause(s) and manner stated.	
	To the within To the comp.	2	only one) 3	Traditioner, To trie t	Soc of fifty		29c. Licens			o, and due to th		te signed (Monti		
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	'		30. Name and address of person who d		•		•		016	DOGUN		MD 20	052	
	Sto	0	GARY E. RAFFEL, N 31. Date filed (Month, Day, Year)	1. D. , 1111	/ KOC	JEV LLLI	E PIKE, S	SULTE	316,	KOCKV.	TTTE	, MD 20	034	
	Stat Registra		MAY 11 2010	2. Registral	A.	pau	Les.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2ÕÏ0 Alvin C. Cooper 112:50a May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Darlington 4129 Flintville Rd. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 29 Year) 1 **X** M 2 □ F Months Country) 71 1939 PA Director 207-30-5796 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Darlington MD Harford 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21034 IISA 4129 Flintville Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 l th and Mental Hygiene. 27 is marked other than "r traumatic event, the Mec (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caraustar Corp. Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Pauline Cooper traumatic Nelson Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 4129 Flintville Rd. Darlington, MD 21034 Doris J. Cooper/ wife Baltimore, 20a. Method of Disposition
1 □ Burial 2 ♣ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/14^D7^t2010 R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 23a. Part 1 Enter the disease, or complica shock or heart failure. List only one of Immediate Cause (Final ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate se ogreach Ine Interval Retwee Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying to (or as a consequence of) and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown P.O. ģ s been signed k should be det 23e. Did tobacco use contribute to the cause of death? þ ney Sease Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed 1 🗌 Yes 2 🗂 No certificate Yes 2 A of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 12 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Naturai 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ledical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in this operation, weath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Chesapeake Dr Bil

cause of death (Item 23a) (Type, Print)

, md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Richard Elwood Chambers May 6, 9:45 p^M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Center Prince George's Adelphi If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 143-18-0870 Director 87 1923 New Jersey Feb. 6, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10120 New Hampshire Ave., #201W 20903 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give WWII
Year or Dates: 1 ☐ Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TV Repairman Electronics is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Hayes Chambers Jeannette Farquhar item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Chambers/Wife 10121 New Hampshire Ave., #201W, Silver Spring, MD20903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 14, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 1 2010 MD Veterans Cemetery 4 Donation 5 Dother (Specify) Cheltenham, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of). Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 I Inknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 210M Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nersing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitai or Attending 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, First)

Year)

32. Registrar's Signature

Adin Crosson 10-03733 **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Day May 15, 2010 0400 hrs Medical Examiner <u>Adin Issac Crossan</u> 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 50 Cedar Hill Circle North East Cecil 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Min. Director 184-82-4566 1 X M 2 F 5 Yrs 11/17/2004 Permyylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10b. County 10a. State is 23a or 28a-f show e notified at once. 1 XXYes 2 No North East permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygion Department of Health and Mental Hygion Important; U item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once Maryland Cecil Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Cedar Hill Circle 21901 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Yes 2 X No White If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Education 0 Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jewel Johnson James Robert Crossan. 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Hopewell Road, Oxford, Pennsylvania 19363 Carol Ring / Grandmother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition May 25, Cremation 3 Removal from State crematory or other place) 1 XXBurial 2 Oxford Cemetery 2010 Oxford, Pennsylvania 4 Donation 5 Other Specify 22. Name and Address of Facility Crouch Funeral Home North East, Maryland21901 South Main Street. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and one each line /Medical Death Smoke inhalation Immediate Cause (Final disease **≛xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed hysician/Medical X UNPENDED AMENDED 27,28a-f, attending physician for use as the burial per ME g909 11/18/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been uneral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred subject was victim of house 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Yes 2 X No Pending fire 5/15/2010 Fd 4:00 am 2 X Accident Investigation 28f. Location (Street and Number of Rural Route Number, City Cedar Hill Circl 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be North East, MD (Specify) Residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certifier O.C.M.E. May 16, 2010 lem 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

OCME

ORIGINAL